Hunterian Society

TRANSACTIONS.

SESSION 1890-91.

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ABSTRACT OF THE

TRANSACTIONS

OF THE

HUNTERIAN SOCIETY,

SESSION 1890-91,

WITH THE

REPORT OF THE COUNCIL,

AND A

LIST OF OFFICERS AND FELLOWS,

ALSO

THE ANNUAL ORATION FOR 1891.

SOCIETY INSTITUTED FEBRUARY, 1819.

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1890 Mackenzie, Wm. J., M.D., ... *Richmond Lodge, 319, Holloway Road, N.*

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1891 Marshall, Thomas, M.A., M.B., *55, Fortess Road, Kentish Town, N.W.*

1889 Martin, John ... ... *129, Clapham Road, S.W.*

1850 **Miller, Claudius M., M.D. ... *100, Stoke Newington Road, N.*

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1890 Oliver, Franklin H. ... ... *2, Kingsland Road, N.E.*

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1864 **Pettifer, Edmund H. ... ... *50, Southgate Road, N.*

1888 Pitt, G. Newton, M.D., (*C*), Assistant Physician to, and Lecturer on Pathology at, Guy's Hospital *24, St. Thomas's Street, S.E.*

1881 Poland, John, Secretary, Visiting Surgeon to the Miller Hospital, Greenwich ... ... *4, St. Thomas's Street, S.E.*

1875 Port, Heinrich, M.D., Physician to the German Hospital, *48, Finsbury Square, E.C.*

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1890 Raw, Wm. E. St. M. ... ... *Oak Bank, Crystal Palace Park Road, Sydenham, S.E.*

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1888 Shaw, Lauriston E., M.D., Assistant Physician to Guy's Hospital, *10, St. Thomas's St., S.E.*

1854 **Shillitoe, Buxton, Surgeon to the Lock Hospital, *2, Frederick Place, Old Jewry, E.C.*

1869 Smee, Alfred H. ... ... *The Grange, Hackbridge, Surrey.*

1887 Smith, Frederick John, B.A., M.D., (*C*), Assistant Physician to the Royal Hospital for Diseases of the Chest, Medical Registrar at the London Hospital ... *4, Christopher Street, Finsbury Square, E.C.*

1890 Starling, Ernest H. ... ... *33, Delamere Terrace, Westbourne Park, W.*

1875 Stevens, George J. B. ... ... *Wadhurst House, Stoke Newington Green, N.*

1869 Stewart, Alexander ... ... *48, Cornhill, E.C.*

1884 Stowers, James Herbert, M.D., Physician for Diseases of the Skin at the North-West London Hospital, *41, Finsbury Square, E.C.*

1880 Symonds, Charters J., M.S., M.D., Vice-President and Orator, Assistant Surgeon to, and in charge of Throat Department, and Teacher of Practical Surgery at, Guy's Hospital, *26, Weymouth Street, Portland Place, W.*

1878 Talbot, Russell M. ... ... *Clarendon House, Bow Road, E.*

1889 Targett, Jas. H., M.B., M.S., Assistant Surgeon to the Evelina Hospital and Demonstrator of Anatomy at Guy's Hospital, *10, St. Thomas's Street, S.E.*

1879 Tatham, Robert G., Vice-President, *69, East India Road, E.*

1869 Tay, Waren, Senior Surgeon to the London Hospital, *4, Finsbury Square, E.C.*

1880 Thorp, Henry J. ... ... *11, Southwark Bridge Road, S.E.*

1869 *Toulmin, Wm. C. ... ... *102, Elm Park Gardens, South Kensington, S.W.*

1890 Tubby, Alfred H., M.B., B.S., Demonstrator of Physiology at Guy's Hospital ... ... *39, Finsbury Circus, E.C.*

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1887	WALLACE, FREDERICK	*96, Cazenove Road, Stamford Hill, N.*
1887	WARNER, PERCY	*Woodford Green, Woodford, Essex.*
1890	WATSON, JOHN A.	*Hay Tor, Dennington Park, N.W.*
1888	WEBB, ALBERT W., M.B. ...	*246, Albion Road, Stoke Newington, N.*
1876	WELCH, CHAS.	*377, Hackney Road, E.*
1876	WHITE, JOHN B., M.D., M.Ch. ...	*14, Portland Place, Lower Clapton, N.E.*
1888	WIGHTWICK, FALLON PERCY, M.B.	*St. John's, Horselydown, S.E.*
1888	WINGRAVE, THOS.	*43, Finsbury Circus, E.C.*
1887	WOODS, JOHN F.	*Hoxton House Asylum, N.*
1882	WORLEY, WILLIAM C.	*103, Green Lanes, N.*
1889	WRIGHT, HOLLAND H.	*2, Ospringe Road, St. John's College Park, N.W.*
1880	YARROW, GEO. E., M.D.	*Oakley House, 317, City Rd., E.C.*

[*It is requested that any change of Title, Appointment, or Residence may be communicated to one of the Secretaries before the Annual General Meeting, in order that the list may be made as correct as possible.*]

CORRESPONDING FELLOWS.

BARLOW, ROBERT	*Orlebar, St. Peters, Isle of Thanet.*
BARNARD, JOHN H., M.D.	*362, Rue St. Honoré, Paris.*
CANFIELD, RALPH M.	*Boston, U.S.A.*
ENGLISH, EDGAR	*Mexborough, Rotherham, Yorks.*
MIDDLEMORE, RICHARD	*Bristol Road, Edgbaston, Birmingham.*
MOON, HENRY	*Pine Lodge, Weybridge Road, Byfleet.*
ROBERTS, BRANSBY, M.D.	*Badlesmere House, Eastbourne.*
TREVES, WILLIAM KNIGHT	*31, Dalby Square, Margate.*

N.B.—Written Communications on Medical Subjects and Donations of Books will be thankfully received.

THE SEVENTY-SECOND ANNUAL REPORT

OF THE

COUNCIL OF THE HUNTERIAN SOCIETY.

The Council of the Hunterian Society is able to report that the Society continues to maintain its flourishing condition in all respects.

During the year the meetings have been well attended, and some valuable papers and instructive communications read before the Fellows.

Thanks to the careful guidance and untiring energy of the President the discussions have been unusually interesting and vigorous.

Amongst other papers the Council would refer particularly to the paper by Dr. Pye-Smith, "On certain points in the Prognosis and Treatment of Heart Disease," to that by Dr. Horrocks on "Puerperal Fever," and to Dr. Turner's investigations of the "Cerebral Lesions in Chorea."

The Clinical and Pathological evenings continue to form a very successful feature, and many valuable specimens and cases have been brought before the Society—especially some illustrating disorders affecting the cutaneous system.

The PRESIDENT, in the hope of obtaining a grant from the City Corporation for extending and improving the Library, has drawn up a petition to the Court of Common Council which will be duly presented next March for their consideration.

The Annual Volume of the Transactions has been further improved by the addition of an index and a more complete binding.

Although the Society has not lost any of its Fellows by death during the past twelve months, yet it must regret the death of Mr. JAMES E. ADAMS, late Surgeon to the London Hospital, who in 1884 was compelled to resign his membership of the Society through ill health.

Mr. ADAMS joined the Society in 1869, was Secretary for six years, Vice-President in 1881–82, and contributed largely to its proceedings. By his kind and genial disposition he endeared himself to all with whom he was brought in contact, whilst as an operator Mr. ADAMS had few equals.

Six Fellows have been elected and two have resigned during the past year, leaving the total number on the roll at 157.

The LIBRARY COMMITTEE has met and examined into the condition of the books and book-cases. They find the state of the books to be satisfactory on the whole.

The Committee beg to call attention again to the absence of any recent Catalogue of the Library, the date of the last being 1869, since which date a large number of books have been added. They also wish to point out to the Fellows the increased facilities for reading which they now enjoy, and which they trust will be further enhanced by the re-issue of a Catalogue.

BOOKS ADDED TO THE LIBRARY

OF THE HUNTERIAN SOCIETY, 1890-91.

The following Works have been presented by the Authors, by the Authorities of the Medical Schools, or in exchange for the Transactions of the Society:—

The Influence of Climate in Pulmonary Consumption.—Dr. C. Theo. Williams.
The Climate of the South of France.—Dr. C. Theo. Williams.
Secondary Degeneration of the Spinal Cord.—Dr. Howard Tooth.
Hunterian Lectures, 1885.—E. Lund.
The Normal Temperature of the Head.– Lombard.
The Regional Temperature of the Head.—Lombard.
Robert Boyle, Inventor and Philanthropist.
Gout.—Dr. Robson Roose.
The Medical Profession.—T. Laffan.
Therapeutics founded on Antipraxy.—Dr. W. Sharp.
The Gravid Uterus.—Dr. W. Hunter (Syd. Soc.).
St. Bartholomew's Hospital Reports, 1890.
St. Thomas's Hospital Reports, 1890.
Guy's Hospital Reports, 1889.
Transactions of the Clinical Society, 1890.
Transactions of the Pathological Society, 1890.
Transactions of the Willan Society, Vol. I.
Index Catalogue of the Library of the Surgeon-General's Office, United States Army, Vol. XI.
Catalogue of the Pathological Museum of the London Hospital Medical College, 1890.
The Sei-I-Kwai Medical Journal.
Local Government Board, 18th Annual Report.

The following Works have been purchased by the Council:—

Encyclopædia of the Diseases of Children, 4 vols.—Dr. Keating.
Atlas of the Pathological Anatomy of the Lungs.—Dr. Wilson Fox.
A Manual of Public Health.—A. Wynter Blyth.
Illustrated Medical News, 5 vols.
New Sydenham Society publications for the year.

REGULATIONS FOR TRANSMISSION OF BOOKS TO FELLOWS FROM THE LIBRARY.

1. A Fellow wishing a Library Book sent to him, may order the book by letter to the Assistant Librarian, enclosing six Stamps in prepayment of carriage and packing.
2. The Library attendant will pack and send Books to Fellows, enclosing the usual receipt form in each parcel with the books, and shall receive twopence for each package so sent.
3. To prevent loss, in case of a Fellow forgetting to send back the receipt, the letter requesting the book to be sent shall be kept by the Assistant Librarian, and the Library Attendant shall keep a list of the books packed by him, and of Fellows to whom they have been sent.

HUNTERIAN SOCIETY.

BALANCE SHEET FOR 1890-1891.

RECEIPTS.

	£	s.	d.
By Balance in hand	37	12	8
„ Subscriptions (including composition fee of £5 5s. 0d. from Dr. Herman)	105	0	0
„ Dividends	8	1	0
„ Vote of Stewards for Library	10	0	0
	£160	13	8

PAYMENTS.

	£	s.	d.
To Purchase of Books and Periodicals	7	17	6
„ Subscription to New Sydenham Society ...	1	1	0
„ Insurance	1	0	0
„ Printing, including the Report, Cards, Lists, Circulars, Notices, &c.	47	9	10
„ Dinner Tickets for invited Guests	3	3	0
„ Stationery and Postages	4	17	5
„ Mr. Williams (Sub-Librarian)	15	15	0
„ Mr. Goodman (Attendant)	5	0	9
„ Messrs. Nelson & Lusher (Porters)	4	4	0
„ Refreshments, Tea, Coffee, &c.	7	10	0
„ Housekeeper's Gratuity	1	1	0
„ Collector's Commission and Expenses	6	10	0
„ Treasurer's Deed Box	1	12	2
„ New Notice Board	0	17	6
„ Balance in hand	52	14	6
	£160	13	8

February, 1891.

(Signed) { WAREN TAY,
JAS. HERBERT STOWERS
T. ROWING FENDICK,
Auditors.

PSYCHOLOGICAL MEDICINE IN JOHN HUNTER'S TIME, AND THE PROGRESS IT HAS SINCE MADE.

THE ORATION OF THE HUNTERIAN SOCIETY FOR 1891, BY FLETCHER BEACH, M.B., F.R.C.P.,

Medical Superintendent, Darenth Asylum; Honorary Secretary, Medico-Psychological Association.

DELIVERED AT THE LONDON INSTITUTION, FEB. 11, 1891.

Mr. President and Gentlemen:—

When you did me the honour to request that I should undertake such an important duty as the delivery of the Hunterian Oration, I had some difficulty at first in deciding upon what subject to address you. The life of Hunter has so frequently been dwelt upon by brilliant orators, such as Paget and others, that it is impossible to bring before you any facts which are not already perfectly well known. On reading the account of his life, one cannot but be struck with his marvellous power of work, his untiring energy and his complete devotion to science in so many departments. Lawrence truly said that "he was the greatest man in the combined character of physiologist and surgeon that the whole annals of medicine can furnish." Physiology, surgery, and the formation of his museum did not take up the whole of his time, for, on looking through the first volume of his "Essays and Observations," arranged and revised by Sir Richard Owen, I was surprised to find that he was also a psychologist. No less than twenty-nine pages are devoted to this subject, and considering that he lived before the time of Herbert Spencer, one appreciates more and more the quality of his genius. Professor Ladd defines psychology as "that science which has for its primary subject of investigation all the phenomena of human consciousness, or of the sentient life of man." Hunter treats of consciousness, the mind, reason, ideas from sensation, fear, deceit, appetites, mental operations, sympathies, appetite and passion, instinct, and many other subjects too numerous to mention, and the remarks he makes are well thought out and ably expressed. Hunter was eminently a practical man, and had he lived, he would no doubt have applied his psychology to the elucidation of many points in surgery and medicine. It therefore occurred to me that the condition of psychological medicine in Hunter's

time and its subsequent progress might be a profitable subject whereon to discourse to you, and although I have since found that you, Sir, in your masterly address last year, treated medicine in a similar way and in a manner which I cannot hope to emulate, yet I have thought I might be able to present to you some facts which may perhaps prove interesting. For many of these I am indebted to my friends, Drs. Hack Tuke, Blandford, and Ireland, who have indicated to me the writings wherein I might obtain information on the subject.

It appears that during the earlier years of Hunter's life the belief that the insane were possessed of the devil had not entirely passed away, and ignorance and superstition guided the treatment. Ducking the lunatic was practised in some parts of Cornwall, and at St. Nun's Pool, situated at Altarnum, eight miles from Launceston, the practice was as follows:—The water from the pool was allowed to flow into an enclosed place, and on the surrounding wall the patient was made to stand with his back to the water, and was then by a sudden blow thrown backwards into it. Then (to quote a graphic description which has been given of it) "a strong fellowe, provided for the nonce, tooke him and tossed him up and downe alongst and athwart the water, until the patient by forgoing his strength had somewhat forgot his fury. Then he was conveyed to the church and certain masses sung over him, upon which handling, if his right wits returned, St. Nunne had the thanks; but if there appeared small amendment he was bowssened againe and againe while there remayned in him any hope of life, for recovery."[1] Bowssen, Dr. Tuke says, means to duck, and is derived from a Cornu-British word, *beuzi* or *bidhyzi*, meaning to baptize, dip, or drown.

In Scotland lunacy-healing wells and superstitions survived to a much later period, and as late as 1793 the insane were taken to St. Fillan's Well. Mr. Heron, the author of a "Journey through part of Scotland," observes that in his day about two hundred persons afflicted in this way were annually brought to try the benefits of its salutary influence.

There is also a famous well on Loch Maree in Ross-shire called Inch Maree, after the name of a saint who lived in the eighth century, which was celebrated for its virtues in the cure of mental disorders. Pennant, author of "Tour in Scotland and the Hebrides," visited it in 1769, and gave an account of the superstitious practices in use there. He says "the curiosity of

[1] Chapters in the History of the Insane in the British Isles, by Daniel Hack Tuke, M.D., F.R.C.P., p. 11.

the place is the well of the saint, of power unspeakable in cases of lunacy. The patient is brought into the sacred island, is made to kneel before the altar where his attendants leave an offering in money; he is then brought to the well and sips some of the holy water; a second offering is made; that done, he is thrice dipped in the lake, and the same operation is repeated every day for some weeks; and it often happens, by natural causes, the patient receives relief, of which the saint receives the credit."[2] I may add that I visited this well about three years ago, and found the altar gone and the well dried up.

In Ireland there are several stories which are connected with the treatment of the insane, the most important of these being that concerning the Valley of the Lunatics. "In the valley are two wells called the 'Lunatics' Wells,' to which the lunatics resort . . . . of these waters they drink and eat the cresses growing on the margin; the firm belief being that the healing water, and the cresses, and the mysterious virtue of the glen will effectually restore the madman to mental health."[3] Branks (or scold's bridles), whipping posts, the pillory and stocks, had been in use before Hunter's time, and as late as 1722, or six years before his birth, a woman was judicially murdered as a witch in Sutherlandshire.

Turning now to the treatment of those who were confined in asylums, or hospitals for the insane, at this time, we find that at Bethlem manacles were applied to the arms and legs of the patients, who were sometimes confined in dark chambers and lay on straw. Many others were kept in gaols, and served as sport to visitors at assizes, fairs, and other times. There was some reason for this, for it appears that in 1744 an Act of Parliament was passed (17 Geo. II., c. 5), which authorised two justices to apprehend any furious or dangerous lunatic, have him locked up, and, if necessary, chained. Pauper lunatics are here referred to. The patients in private asylums were no better off, for, according to a writer in the *Gentleman's Magazine* in 1765, "persons were taken forcibly to these houses without any authority, instantly seized by a set of inhuman ruffians trained up to this barbarous profession, stripped naked, and conveyed to a dark room. If the patient complains, the attendant brutishly orders him not to rave, calls for assistants, and ties him down to a bed, from which he is not released until he submits to their pleasure. Next morning a doctor is gravely introduced, who, taking the report of the keeper, pronounces the unfortunate person a lunatic, and declares he must be

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[2] Ibid, p. 17. [3] Ibid, p. 23.

reduced by physic. He is deprived of all communication with the outer world, and denied the use of pen and paper." Sane people were sometimes confined in these asylums, for persons frequently availed themselves of the facilities then in use, in order to get rid of a troublesome relative or to obtain some selfish object. Matters at length became so bad that a Committee of the House of Commons was appointed to enquire into the state of the private mad-houses of the kingdom. No result followed until 1774, when the Act (14 Geo. III., c. 49) was passed. By this it was enacted that five Fellows of the College of Physicians should be annually elected Commissioners in Lunacy, for granting licenses in London and Westminster and seven miles round, and in the County of Middlesex. If no Fellows of the College would serve, the Commissioners might be chosen out of the Licentiates. The Commissioners were to licence houses annually in the metropolitan district, and visit them at least once a year. One guinea was to be paid to each Commissioner for every visitation of a licensed house, together with his expenses. In the provinces houses were licensed by the Justices of the Peace, and two Justices and a Physician were chosen for each County, who were to visit and inspect asylums as often as they thought fit. This Act did not extend to public hospitals or to pauper patients.

The medical treatment at this time consisted in bleeding, purging, and giving emetics, probably with the idea that insanity was due to excess of bile in the blood, which was to be got rid of by phlebotomy, emetics, and purgatives. John Wesley, it seems, prescribed for insanity, one of his remedies being a diet of apples exclusively for a period of a month. In all hypochondriacal cases, and in obstinate madness, Wesley recommended the following prescription:—"Pour twelve ounces of rectified spirits of wine on four ounces of roots of black hellebore, and let it stand in a warm place twenty-four hours. Pour it off and take from twenty to thirty drops in any liquid fasting."[4]

The views of the medical authors of that day are interesting. Dr. Fallowes, in his work entitled "The Best Method for the Cure of Lunatics, with some Accounts of the Incomparable Oleum Cephalicum used in the same, prepared and administered," says:—"The proper seat of madness is the brain, which is disturbed by black vapours which clog the finer vessels through which the animal spirits ought freely to pass, and the

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[4] Ibid, p. 109. Quoted from Wesley's "Primitive Physic, or an Easy and Natural Method of curing most Diseases."

whole mass of blood, being disordered, either overloads the small veins of the brain, or by too quick a motion, causes a hurry and confusion of the mind, from which ensues a giddiness and at length a fury. The abundance of bile, which is rarely found to have any tolerable secretion in such patients, both begets and carries on the disorder." [5] To cure this he prescribed his oleum cephalicum, which raised pustules on the head, and was said to compose and allay the animal spirits.

Dr. Pargeter, in his "Observations on Maniacal Disorders," after dwelling on the pathology, causation, and nature of insanity, says:—"Here our researches must stop, and we must declare that wonderful are the works of the Lord, and his ways past finding out." [6] He is pleased with the management of asylums, and with respect to private madhouses under the management of regular physicians, he is of opinion that lunatics are properly treated, though in private asylums kept by non-medical persons, if the "gaolers of the mind do not find a patient mad, their oppressive tyranny soon makes him so."

Cullen, in his "First Lines of the Practice of Physic," Vol. IV., treats of *vesaniæ*, or disorder of the intellectual functions, mania, melancholia, and other forms of insanity, at some length. Insanity he considers as a genus comprehending many different species, and he thinks "it is very probable that the state of the intellectual functions depends chiefly upon the state and condition of what is termed the nervous power, or as we suppose, of a subtle, very moveable fluid, included or inherent, in a manner we do not clearly understand, in every part of the medullary substance of the brain and nerves, and which in a living and healthy man is capable of being moved from every one part to every other of the nervous system." For mania, which he believes to be due to inequality of excitement, restraint, he says, is useful, and he thinks the strait waistcoat a good way of applying it. As lunatics are susceptible to fear, he considers it necessary to inspire them with awe and dread, not only by restraint but sometimes by stripes or blows. The former he thinks is safer, but neither should be used "when the maniacal rage is either not susceptible of fear, or incapable of remembering the objects of it." A low and spare diet he deems useful, in order to diminish the fullness of the system. Blood-letting, "purging, particularly by the soluble tartar," vomiting, frequent shaving of the head, blistering, cold bathing, especially by throwing the madman into cold water by surprise,

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[5] Ibid, p. 93. [6] Ibid, p. 512.

are all of use, and for medicines he prescribes opium and camphor. He is of opinion that "in the mania of sanguine persons, bloodletting and other antiphlogistic remedies are more proper, and have been more useful, than in the melancholic." Melancholia, he says, must be distinguished by its always being attended with some seemingly groundless, but very anxious, fear. In it "there is a degree of torpor in the motion of the nervous power, both with respect to sensation and volition; there is a general rigidity of the simple solids, and the balance of the sanguineous system is on the side of the veins." He thinks it probable that the melancholic temperament depends upon a drier and firmer texture in the medullary substance of the brain, and he treats the disease by purgatives, warm bathing, sometimes opium and low diet, avoiding the use of vegetables. As regards exercise, he believes that it may be useful in many cases of mania, hypochondriasis and melancholia, not as a tonic, but as regards its effects upon the mind.

Dr. Arnold's work, "Observations on the nature, kinds, causes, and prevention of Insanity," is of a classical nature. He attempts to define the varieties of Insanity, with the idea, as he says in his preface, of a greater precision in the knowledge of the disorder and a greater efficacy in the methods of cure; and he follows the example of Sydenham, who recommended that every disease should be reduced to certain and determinate species. Insanity, according to him, consists of two kinds, melancholy and mania; in both there is a permanent delirium, but in the former, there is no fury nor fever, and the mind is dejected, timorous and usually employed about one object; in the latter there is fury and audacity, but without fever. Many quotations from the works of Hippocrates are given, and the author decides to divide Insanity into two kinds, viz., Ideal and Notional, the former consisting of four species, the latter of thirteen, and one of these, Pathetic Insanity, is again subdivided into sixteen varieties. The appearances of the body post mortem, according to Bonetus, Morgagni and Haller, are fully described, and the various bodily, mental and proximate causes are discussed and examined. Very little attention is given to the cure of Insanity, but his views on its prevention are as true now as they were in his day. Temperance in all things, exercise, the due regulation of the passions, attention to the operations of the imagination, an assiduous diligence in the improvement of the reasonable faculties of the mind, the careful avoidance of too long continued, too intense, and too uniform thinking, and rational views of God and religion are the chief means prescribed.

Lastly, we have the book entitled "Practical Observations on Insanity" by Dr. J. Mason Cox, of Fishponds, near Bristol. It is a practical work, in which the author does not concern himself with abstruse speculations, but simply describes, as a result of his own experience, the method of treating diseases of the intellect. Insanity is divided by him, as was the case with the authors previously quoted, into mania and melancholia. The history of a maniacal attack is given, and the predisposing, exciting and proximate causes are fully entered into. Twenty-one cases are related, and the diagnosis, prognosis and especially the treatment are discussed and described. He appears to be the first to lay much stress on *moral* as accessory to *medical* treatment. Management he looks upon as of the highest importance, and he observes that it partly consists in address, but principally is displayed by making proper impressions on the senses. Sympathetic tenderness, as well as steadiness and presence of mind, must never be forgotten, for often more is done by firmness and tenderness than by violence and harshness. He here approaches the ideas of treatment of the present day, as also in his statement that corporal punishments, such as stripes, are in no case necessary or admissible, though he believes that the strait waistcoat and other means of coercion are often necessary. He distinguishes between the sthenic and asthenic forms of insanity, and sees very clearly, that though it is usual to pursue the antiphlogistic plan in the former cases, it is highly improper in the latter, in which a generous diet, bark, port wine, &c. are indicated. Altogether he is much in advance of the treatment of his time. He agrees that bleeding, blistering, and the production of vomiting and purging are necessary, and he prescribes opium, camphor and digitalis in certain cases. A very novel treatment on his part was swinging the patient, which he describes as both moral and medical. It was employed in the oscillatory or circulating form. He regards it as a medical anodyne, as a means of exciting vomiting, and as a species of punishment, which the physician can employ to secure compliance with his wishes.

We come now to the year 1792, a year before Hunter's death, when an important event occurred which proved to be the beginning of the reform that ultimately took place in the condition of all British Asylums. It was the dawn of better days in the treatment of the insane. It seems that there was in York at this time an asylum, which was a frightful abode for lunatics, and the friends of a patient confined there, who desired to see her, were refused admission. Suspicion was aroused, and though no exposure was at this time made, William Tuke, a

citizen of York, proposed the erection of an institution where there should be no concealment, and where the patients should be kindly and humanely treated. His proposition was adopted, funds were provided, and in 1796 the York Retreat was opened and the experiment started. The central idea of the treatment there pursued was an active humanity. William Tuke "had a strong faith in the dictates of an enlightened conscience, and in the perfect wisdom and love which direct every law of human duty." [7] Patients were regarded as human beings and were treated with kindness and compassion, and as a result restraint was found to be comparatively seldom required. Blood-letting, emetics and purging were no longer used, a nourishing diet was prescribed, but medical treatment was not discarded. The Institution was made as much as possible a home with cheerful surroundings, and the patients were encouraged to work in the open air. Mild forms of restraint were now and then employed when kindness or medical remedies had no influence, there being no rule that this practice should not be resorted to, the Directors of the Retreat preferring to leave to their officers discretion in the management of each individual case. It is interesting to note that the compassionate treatment of the insane also commenced in France about this time, for Pinel in the year 1793 had freed the lunatics at the Bicêtre from their fetters, although he did not know until 1798 that the same humane treatment was pursued in England. It is generally understood that he did not liberate them for medical reasons, but chiefly from the compassion which he felt for their pitiable condition. As a result, his knowledge of insanity was greatly increased, and the classification from symptoms adopted in his book is still regarded as one of high merit.

Having given you an account of the condition of psychological medicine during the life of Hunter, I now proceed to point out the progress which has since been made. The system of treatment practised in the Retreat was not followed for some time. Its success excited the jealousy of the superintendent of the York Asylum; discussion followed, and eventually an investigation was set on foot which necessitated legislation. Various Acts of Parliament have from time to time been passed, and the result has been the humane treatment of lunatics as seen at the present time.

I mentioned just now that in 1774 an Act was passed for regulating madhouses, and we learn something of its working from the evidence taken before the Select Committee appointed

[7] "Review of the Early History of the Retreat," by S. Tuke, 1846.

in 1815 to consider "of Provision being made for the better Regulation of Madhouses in England." Evidence was taken from various witnesses relative to the condition of patients in the York and Bethnal Green Asylums, and in Bethlem Hospital —the second one, near Moorfields. Mr. Wakefield, reporting his visit to Bethlem, said:—"Attended by the steward of the hospital, and likewise by a female keeper, we proceeded to visit the women's galleries. One of the side rooms contained about ten patients, each chained by one arm or leg to the wall, the chain allowing them only to stand up by the bench or form fixed to the wall, or to sit down to it. The nakedness of each patient was covered by a blanket-gown, only the blanket-gown was a blanket formed something like a dressing-gown with nothing to fasten it in front; this constitutes the whole covering; the feet were even naked." This, however, did not seem to strike the public mind so much as the case of William Norris, who was secured, according to Esquirol, in the following way:—"A short iron ring was riveted round his neck, from which a short chain passed to a ring, made to pass upwards and downwards on an upright massive bar more than six feet high, inserted into the wall. Round his body a strong iron bar about two inches wide was riveted; on each side of the bar was a circular projection, which, being fastened to and enclosing each of his arms, pressed them close to his side." At the York Asylum the treatment was just as bad. Cells were discovered, four in number, eight feet and a half square, perfectly dark when the door was shut, and the stench almost intolerable; in these cells thirteen women slept. Many cases of gross neglect were discovered; the body of a patient who had been killed was hurried away to prevent an inquest; in addition, two sets of account books were kept, and a portion of the asylum was burned down, involving the deaths of patients and destruction of what the authorities wished to conceal. At the Bethnal Green Asylum "several of the pauper women were chained to their bedsteads naked, and only covered with a hempen rug; the accommodation for paupers was infamously bad and required immediate reform." [8] The liberty of the subject was evidently a secondary consideration; the primary one was the regulation of madhouses. A private patient could be sent to a licensed house on one medical certificate, and a pauper without any at all. There was hardly any visitation or inspection by the Commissioners, and they had no power to release the patients. The effect of this parliamentary enquiry, though exceedingly great, did not

[8] Minutes, Select Committee of the House of Commons, 1815.

then bring about a new statute, and no less than thirteen years elapsed before a radical alteration of the law took place. In 1828, the ninth year of George IV., an Act was at length passed to remedy the defects of that of 1774. By it, fifteen persons were appointed Commissioners in Lunacy for the metropolitan district for one year; five were to be physicians, and they were to be paid £1 per hour. They were to meet quarterly for the purpose of granting licences, those in the provinces being granted by justices at the Quarter Sessions, where three or more justices were to be elected to visit the provincial licensed houses, together with one or more medical men.

A year later further impulse was given to the humane treatment of patients, initiated by Mr. Tuke in 1792, for it seems that, according to Conolly in his "Treatment of the Insane," in the year 1829 a patient in Lincoln Asylum had died, "in consequence of being strapped to a bed in a strait-waistcoat during the night; and this accident led to the establishment of an important rule, that whenever restraints were used in the night, an attendant should continue in the room; a rule which had the desired effect of much diminishing the supposed frequency of such restraints being necessary."

In the year 1834, it was found that this principle which acted so well at night was also applicable by day, and the result was that the necessity for restraint became less frequent. In 1835, Mr. Gardiner Hill was appointed house-surgeon of the Lincoln Asylum, and from this date a new era—that of non-restraint—was inaugurated in the treatment of the insane. By many, the name of Dr. Charlesworth, visiting physician to the Asylum, has been associated with that of Mr. Gardiner Hill as an equal labourer in carrying out this treatment, but it appears that though Dr. Charlesworth warmly seconded Mr. Gardiner Hill in his attempt at doing away with the restraint system, the true inventor was Mr. Hill. In the report of 1838, which is signed by the Chairman of the Visiting Committee, E. P. Charlesworth, the merit of the idea is ascribed to the house-surgeon. "There is now," says the Report, "an increased confidence that the anticipations of the last year may be fulfilled, and that an example may be offered of a public asylum, in which undivided personal attention towards the patients shall be altogether substituted for the use of instruments of restraint. *The bold conception* of pushing the mitigation of restraint to the extent of actually and formally abolishing the practice, mentioned in the last report as due to Mr. Hill, the house-surgeon, seems to be justified by the following abstract of a Statistical Table, showing the rapid advance of the abatement

of restraint in this asylum, under an improved construction of the building, night watching, and attentive supervision."[9] The table shews that the number of hours passed by patients under restraint diminished from 20,423 in 1829 to 0 in 1838. Although the experiment was a success, yet the remote position of the institution, and the want of authority in its author, would have prevented its acceptance by others for years, if Dr. Conolly, on going to Hanwell in 1839, had not set to work to carry it out in the then largest asylum in the kingdom. In a letter written to his friend, Mr. Hunt, of Stratford, he says, " I know you will feel glad that we have now ruled this great house (there were 800 patients) for four months without a single instance of restraint by any of the old and objectionable methods. The use of strait-waistcoats is abolished, hand-straps and leg-locks never resorted to, and the restraint-chairs have been cut up to make a floor for the carpenter's shop. All this, of course, occasioned some trouble and some anxiety, but the success of the plan and its visible good effect abundantly repay me." [10] About this time Mr. Gaskell introduced it at the Lancaster County Asylum with 600 patients, and as a result, no less than nineteen tons weight of iron bars, gates and paraphernalia connected with restraint were completely removed from the building. These movements were not effected without much opposition, and Mr. Gardiner Hill on introducing the system, not only had the whole of the staff of attendants against him, but the superintendents of the other asylums assailed him, denouncing his system as Utopian, empirical, and highly dangerous to the patient and those around him.

In 1842 another Act of Parliament was passed (5 and 6 Vic., c. 87), by which the number of physicians on the Commission was increased to six, and that of barristers to four. A patient might be set at liberty after two visits, and the provincial licensed houses were to be visited twice a year by the Metropolitan Commissioners in addition to the visits of the Justices. The Commissioners were to report whether non-restraint was in practice in any of the asylums, the number of attendants, the amusements and occupations of the patients, and generally the condition of the asylums. They made a thorough investigation, and presented a valuable report to Parliament in 1844. It comprised the result of their enquiries and visits at the seventeen county asylums, the two naval and military hospitals,

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[9] " Lunacy : its Past and Present " by Robert Gardiner Hill, p. 38.

[10] Quoted from " The Borderlands of Insanity," by Andrew Wynter, M.D. p. 102.

the eleven public hospitals, the one hundred and thirty-six licensed houses, and a number of workhouses then in operation. The number of lunatics at that time known to exist were 20,893, of whom 16,821 were pauper and 4,072 private patients; a few of these were not in asylums, but were single patients under commission. Some of the asylums visited were in a disgraceful state, the abuses found being survivals of the past, but those at Wakefield, Hanwell, Lincoln, Lancaster and Gloucester were well managed. In the badly managed ones, refractory patients were confined in strong chairs, or restrained by leg-locks, iron hand-cuffs or fetters from the wrists to the ankles. In some asylums there were no windows to the sleeping rooms, and no place for light or air, except a grate over the doors. There was considerable difference of opinion among the superintendents of the asylums in reference to the subject of restraint; for, while some made no use of it except for surgical reasons, others considered it beneficial, less irritating than holding with the hands, and valuable as a precaution and remedial agent. In July, 1844, Lord Ashley, afterwards Lord Shaftesbury, moved for an address to the Crown, praying Her Majesty to take into consideration the report of the Metropolitan Commissioners, and eventually he brought forward two bills. By the first, he proposed to establish a permanent Commission of Lunacy, consisting of six paid commissioners, who were to be debarred from taking any other office or duty, and who were to visit the asylums more frequently. Lunatic hospitals were required to have the same orders and certificates as licensed asylums, and the same visitation as county asylums; a return was to be made of all single patients received for profit; and workhouses containing lunatics were to be regularly visited. By the second, the erection of borough and county asylums, instead of being permissive, was made compulsory; all lunatics found wandering were taken to asylums, and a quarterly inspection by a medical man of all lunatics not in asylums was made compulsory, and a list sent to the Commissioners in Lunacy. These bills passed both Houses of Parliament and received the Royal assent in August, 1845. As a result of this legislation, the Commissioners in their second report dated 1847 say, "that they have found that, with some exceptions, the patients have apparently been humanely and sometimes very judiciously treated. There is no reason to apprehend that the lunatic patient is now often subjected to cruelty or ill-treatment. The massive bars, and rings, and chains of iron formerly resorted to are no longer seen. Any continued coercion is not permitted. The name of every patient under restraint and in seclusion, and

the means by which such seclusion is effected, are recorded every week in a journal. Thus the safe-guards against lunatic patients being subjected to harsh or unnecessary restraint from the cruelty, idleness, or caprice of their attendants have been multiplied, and the chances of abuse reduced to a small amount."

In 1853 the Act of 1845 was amended, and that of 16 and 17 Vict., c. 96 came into force. By this, persons who had been patients might be received in an asylum as boarders. Transfers of patients were instituted, various regulations were made with regard to single patients, and Bethlem Hospital was no longer exempted from visitation by the Commissioners.

In 1859, after great excitement and agitation concerning private asylums and the Lunacy Laws, a Select Committee of the House of Commons was appointed to inquire into the operation of the Acts of Parliament and the regulations for the care and treatment of lunatics and their property. The evidence brought forward convinced the Committee, that, with regard to public asylums little alteration was required in the law, but that the chief evil lay in the detention of a large number of pauper lunatics in workhouses. They suggested various precautions as safe-guards against the improper detention of lunatics in private asylums, and made other suggestions with reference to Chancery lunatics, criminal lunatics, and the composition and powers of the Lunacy board. In 1862 an Act was passed to amend the law relating to lunatics, but the alterations made were comparatively trifling. Some changes were made with reference to the certificates and orders of admission, and the Commissioners' visits were increased in number. Pauper lunatics were made chargeable upon the common fund of the Union, the improper admission of patients into asylums was prevented, and the abuse of private asylums was guarded against.

The next important movement was the Act of 1867, commonly called Gathorne Hardy's Act, which provided asylums for the sick and for the chronic insane poor of London. Three have since been erected: one at Leavesden, one at Caterham, and one at Darenth; they are known as the Metropolitan District Asylums. The primary object in erecting them was economy, and as far as one can judge the experiment has proved successful.

In 1877 a feeling of uneasiness arose in the public mind, in consequence of an impression that patients were too easily admitted into asylums, and when there, could only with difficulty get out. A Select Committee was appointed, known as Mr. Dillwyn's Committee, to enquire into the subject. Many false charges were made, which, on being strictly investigated,

fell to the ground. Various proposals were suggested, which were embodied in a Bill, introduced into Parliament by Mr. Dillwyn in 1881. The Bill did not reach the stage of the third reading, but after being introduced in successive Parliaments, finally received the Royal assent in 1889. A consolidation of this and previous Acts was passed last year. The chief objects of this Act of 1889 are "(1) to furnish safe-guards against the improper confinement of persons as lunatics, who shall only be detained under the order of an independent authority, to secure speedy treatment, and to protect medical practitioners and others in the performance of their duties; (2) to amend the law as to single patients; (3) to give increased power for administering the property of lunatics; (4) to check the establishment of new licensed houses; (5) to enable public asylums to receive private patients." [11] Under the provisions of this bill, no private patients, with the exception of those found lunatic by inquisition, can be confined, except upon an order of the Justice of the Peace, who, upon application being made to him, accompanied by a statement of particulars and two medical certificates, will, if he sees fit, issue an order, authorising the superintendent or proprietor of an asylum, hospital, or licensed house to receive the patient. Pauper patients can be received upon the order of a justice, accompanied by the particulars of the case and one medical certificate. In cases of urgency, where it is expedient for the welfare of a person, not a pauper, alleged to be a lunatic, or for the public safety, to place him forthwith under care and treatment, he may be received and detained in an institution for lunatics, or as a single patient in a private house, upon an urgency order made, if possible, by the husband, wife, or relative of the alleged lunatic, accompanied by one medical certificate. This order remains in force for seven days, or if a petition for a reception order is pending, until the petition is finally disposed of. Private patients may be discharged on the application of the person by whose means the lunatic was received into the asylum; by the Commissioners in Lunacy; and by the Committee of Visitors of the Asylum; and a pauper, on the application of the guardians who maintain him in the asylum, or relative or friend of the patient, who placed him there.

Time does not admit of my tracing the progress which has been made with regard to our Criminal and Chancery lunatics, or to the changes in the treatment of patients in Scotland and Ireland; suffice it to say that in these parts of the United Kingdom the condition of lunatics has immensely improved.

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[11] "Journal of Mental Science," October, 1889, p. 479.

With regard to the classification of mental diseases, various systems and principles have been laid down. All of them, as Dr. Blandford says, "are based on one or other of three principles. Either they are framed according to the mental peculiarities of the patient, his exaltation, his depression, his imbecility; or they point to a disorder of one or other of the portions into which the human mind is by some authors divided; or, the mental symptoms being put entirely aside, the malady is classified according to its pathological cause, and its relations to the bodily organism." [12] I will not weary you by recounting them, but will simply remark that the division into Mania and Melancholia adopted by the old writers is the foundation of the whole system, and that later advances have, as time has gone on, been due to a more scientific study of mental disease. For my part, I think the classification promulgated by Dr. Clouston is one of the simplest. Excluding the varieties of each form of insanity, the classification is as follows:—1. States of Mental Depression; 2. States of Mental Exaltation; 3. States of Regularly Alternating Mental Conditions; 4. States of Fixed and Limited Delusion; 5. States of Mental Enfeeblement; 6. States of Mental Stupor; 7. States of Defective Inhibition; 8. The Insane Diathesis.

Great progress has been made in our views of the nature of insanity. The old writers were of opinion that it was due to excess of bile in the blood, and hence the blood-letting, purgative and emetic treatment. It would take too much time to study the various doctrines that have been held, but there is no doubt that the views of Laycock, Carpenter, Monro, Anstie, Thompson Dickson and others have all contributed to make more clear to us that insanity is due to depression of the higher centres and excessive action of others. Dr. Hughlings Jackson, adopting the hypothesis of evolution as laid down by Herbert Spencer, thinks that cases of insanity may be considered as examples of dissolution, which is of course the exact reverse of evolution. According to this view, insanity is dissolution beginning at the highest nervous centres. In two articles on the "Comparative Study of Drunkenness," published in the *British Medical Journal* of the 16th and 23rd May of 1874, he pointed out that not only by alcohol and epilepsy, but also by insanity the patient is *reduced* to a more automatic condition of mind, just as in a case of aphasia he is reduced to a more automatic condition of language, and to a more automatic condition of movement in hemiplegia. We find overaction of lower

[12] "Insanity and its Treatment," Blandford, 2nd ed. p. 127.

centres from the removal of the influence of the higher ones, and he enumerates four factors, according to which the mental automatism may vary. "1. It will vary according to the *depth* of the reduction. The 'shallower' this is, the higher and more special is the automatic mental action permitted. 2. The *rapidity* with which the reduction is affected will influence the extent. 3. The insanity of the person whose brain is reduced will vary according to the normal peculiarities of the individual, no two persons being alike. 4. It will vary according to the influence of external circumstances and internal bodily states."[13] This doctrine may be regarded as the one usually held by the more advanced scientists of the present day. No doubt the researches initiated by Fritsch, Hitzig and Ferrier, and carried on by Horsley, Schäfer and others in this country, and by Goltz and Munk on the continent, will in time shed more light on this difficult subject.

The pathology of insanity has, of late years, made great strides, and I think we have reason to hope that, as time advances, we may be able to connect the mental symptoms seen during life with the appearances found after death. Since Parchappe published his "Recherches" nearly fifty years ago, many contributions, too numerous to mention, have been made to the subject. Drs. Bucknill and Boyd were among the first in this country to work at it, and they have left on record many observations on the weight of the brain, and the changes which take place in that organ, its membranes and the spinal cord in general paralysis. Drs. J. Batty Tuke, Crichton Browne, Savage, Mickle, Herbert Major, and lastly Bevan Lewis in this country and Professors Westphal, Hitzig, Voisin and others abroad have all advanced our knowledge of the pathology of the brain in mental disease. The latest book on the subject, that of Bevan Lewis, is the result of many years of patient, diligent work, and contains more than 100 pages on the morbid conditions of the cranial bones, brain, spinal cord and their membranes, which are found in connection with mental disease. The chief feature of the book is the development and application of the studies of the author in the lymphatic system of the nervous centres. According to him, the lymphatic system of the brain consists of (1) "a distensible lymphatic sheath, loosely applied around the arterioles and venules . . . the adventitial lymph sheath . . . included within the perivascular channel of His; (2) of a continuation of the cellular elements of this sheath, loosely applied to the

[13] Footnote on p. 46 of Blandford's "Insanity and its Treatment."

arterio-capillary plexuses, still contained within a perivascular channel, which now exhibit . . . . perivascular sacs, within which the nerve cell lies, surrounded by plasma; (3) of a system of plasmatic cells with numerous prolongations, which are always in intimate connection with the adventitial lymph sheath, and which drain the areas between the vascular branches —these we have termed the lymph-connective elements." This lymph-connective system plays an important rôle in the pathology of the brain, for we find that the Dieters' cells, or spider cells, are morbidly developed and undergo a hypertrophic condition, in morbid states of the brain and membranes which lead to obstruction of the perivascular lymph channels. Concurrently with this morbid transformation, the nerve cells become degenerated and eventually a dense fibrillation occurs. Bevan Lewis thinks that the spider cell is a scavenger cell, which acts as a "phagocyte" and devours nerve elements. He believes that *even now* it is possible in a large proportion of cases to establish a relation between the physical appearances seen after death and the lesions of intellectual function observed during life. Excluding the more recent instances of acute insanity, he tells me he can do this in epilepsy, alcoholism, general paralysis, idiotcy (in this I agree with him), chronic melancholia, senile dementia, and a large group of consecutive dementias, including "organic" dementia. That so much can already be accomplished is a result of which we may justly be proud.

Coming now to the treatment pursued at the present day, we find the wards in asylums well furnished and made cheerful-looking with birds, aquariums, plants, flowers, and pictures on the walls; and communicating with them are well-planted and well-kept airing courts. In some parts of the country the tendency has been to do away with the huge buildings characteristic of the older asylums, and to build cottages, or, in higher class asylums, villas upon the estate. The conditions of life more nearly resemble those of home, and it is found that patients can be just as conveniently classified and treated. In Scotland the most important change has been to allow greater liberty to the patients; in some asylums the airing courts have been abolished, locked doors have to a great extent been disused, and many quiet harmless cases are boarded out under medical supervision. The tendency now is to think less of the security of the patient, and to grant as much freedom, compatible with safety, as possible. Many suitable cases are treated in the houses of medical men, or in lodgings, under medical care. Industrial occupation, especially in the open air,

is of great use. Work on the farm for the men, and in the laundry and kitchen for the women, tends to improve their bodily and mental health, and so is an aid to recovery. No doubt mechanical restraint in some cases can never be abolished ; indeed this is recognised by the Lunacy Act of 1890, and the Commissioners in a recent circular acknowledge " that cases will occur in which it is necessary for the safety of the patient, or of others, or is beneficial to the patient, that restraint should be applied." They hold, however, " that the application of it should be restricted within the narrowest limits possible, that the restraint should be applied by means the most humane that can be contrived, should not be long continued without intermission, and should be dispensed with immediately it has effected the purpose for which it is employed."

Combined with the moral treatment, which comprises the personal influence of the physician upon the patient, and the order, discipline, work and amusements found in all well managed asylums, is the medical, which includes the hygienic treatment. Diet and regimen are of the highest importance. Fatty foods, easily digested animal and farinaceous food and nourishing ale and porter are very useful, and though the patient may be too weak for out-door work, yet exercise, or even sitting out in the fresh air, is now insisted upon. Laxatives, enemata, and even strong purgatives are sometimes required, but mild medicines should be tried first. The presence of gout, rheumatism, syphilis, phthisis or epilepsy in the patient of course requires appropriate remedies. Tonics, diuretics, the use of the Turkish bath and the wet pack, and the bromides, chloral, sulphonal and paraldehyde are often beneficial, but opium, as a rule, is not often required. For the carrying out of this treatment, good attendants, who possess some knowledge of mental disease and are acquainted with a few simple rules in nursing, are essential. Many such are found in all our asylums at the present day, but the Council of the Medico-Psychological Association have elaborated a scheme, by which attendants, on going through a prescribed course of lectures and instruction in the wards and on successfully passing an examination, may obtain a certificate, which will not only be of use to them when passing from one asylum to another, but will be a guarantee to the general public that the possessors of these certificates have attained proficiency in nursing and attendance on insane persons. The Council of the same Association is also now engaged in formulating resolutions, directing attention to what is known as the hospital treatment of insanity in the asylums throughout the country. Much has been done by the appointment

of clinical assistants and pathologists in some institutions, but there is no doubt a much larger medical staff is urgently required. Nor should I omit to mention in connection with the subject of treatment, that a society for the after-care of the insane has for some years been at work. It is generally recognised that it is unwise to turn out into the world patients only just recovering from grave diseases, and hence convalescent institutions have in many cases been built in connection with our general hospitals, where men and women may breathe fresh air, enjoy beautiful scenery, and gradually be fitted to return to the duties of their daily life. In the same way the After-care Association of the Insane assists patients recently discharged from asylums, by boarding them out in cottages under the superintendence of local friends, and subsequently finding employment for a large number of suitable cases.

In summing up the difference between the old and new treatment of the insane, I cannot do better than quote the words of Dr. Hack Tuke, who says, "The old system believed in harshness and darkness; the creed of the new is sweetness and light."

Passing now to that department of psychological medicine with which I have for many years been closely connected, viz., the treatment of idiots and imbeciles, I would remark that the idiot was a being not unknown to Hunter. In his Essays and Observations before referred to, under the heading "Periods of Life, according to Appetites and Mental Operations," he says, "The state of the idiot is one where impression produces sensation, not upon the mind, but upon the body; where the mind never makes an application of the present sensation to another; and where, when the present sensation is gone, it never recurs." Although this is not quite correct, with respect to all classes of idiots and imbeciles, yet, as little was known about their treatment at the time when Hunter wrote, it is sufficiently good as a general statement.

There is the greatest possible difference between an idiot and lunatic; this was clearly understood by the old legal authorities, for on referring to Shelford's Law of Lunatics, I find an idiot defined as "a person who has been without understanding from his nativity, and whom the law therefore presumes never likely to attain any"; while a lunatic is "one who has had understanding, but by disease, grief or other accident, hath lost the use of his reason. A lunatic is properly one who has lucid intervals, sometimes enjoying his senses, and sometimes not." Idiocy may come on some years after birth, so that the legal definition of an idiot as one who has been without

understanding *from his nativity* is not strictly correct. Esquirol's definition is good; he says, "the man that is mad is deprived of possessions which he formerly enjoyed, it is a rich man become poor; whereas the idiot has always been in misfortune and misery." Medically speaking, idiocy arises from defective development or disease of the brain, occurring before birth or in early childhood, and as a consequence, the subject of these conditions is mentally deficient. Imbecility is usually understood to be a less degree of mental incapacity than appears in idiocy, though the two conditions often shade off almost imperceptibly one into the other.

The first idiot who attracted the attention of scientific men was the savage of Aveyron. He was a child about 11 or 12 years of age who had lived for some time in the woods of Caune in France, where he subsisted on acorns and roots. Towards the close of the year 1798 he was caught by three sportsmen, who "conducted him to a neighbouring village and put him under the care of an aged matron, from whom, however, before the end of a week, he contrived to escape and fled to the mountains, where he wandered about during the severity of a most rigorous winter, clad only in a tattered shirt. At night he retired into solitary places, approaching, as the day advanced, the neighbouring villages; and in this manner he passed a vagrant kind of life, till the time in which, of his own accord, he sought refuge in a dwelling-house in the Canton of St. Sernin."[14] He was eventually taken to Paris, where he arrived in the year 1799, under the care of a poor, but respectable old man, who soon after had to leave him. Brilliant expectations were formed by the people of Paris before his arrival. Some, thinking that his education would only be a business of a few months, looked forward to the time when he would be able to relate his observations concerning the manner of life he formerly led. Instead of this, they saw a disgusting boy, who bit and scratched those who contradicted him, and who cared for nobody and for nothing. Curiosity was first excited, but was soon followed by general indifference. Pinel, physician-in-chief to the insane at the Bicêtre, declared him to be idiotic, while Itard, physician of the Deaf Mute Institution, asserted that he was simply wild and untaught, and undertook his education. He stated that his objects were:—(1) "to attach him to social life, by rendering it more pleasant to him than that which he was then leading, and, above all, more analogous to the mode

[14] "An Historical Account of the Discovery and Education of a Savage Man," by E. M. Itard, 1802, pp. 13 and 14.

of existence he was about to quit ;—(2) to awaken the nervous sensibility by the most energetic stimulants, and sometimes by lively affections of the mind ;—(3) to extend the sphere of his new ideas, by giving him new wants, and by increasing the number of his relations to the objects surrounding him ;—(4) to lead him to the use of speech by subjecting him to the necessity of imitation ;—(5) to exercise frequently the most simple operations of the mind upon the objects of his physical wants ; and at length, by inducing the application of them to objects of instruction." [15]

At the end of five years, although he had immensely improved the boy, Itard was convinced that Pinel was right, and gave up his task in disgust, remarking "Unfortunate ! since my pains are lost, and my efforts fruitless, take yourself back to your forests and your primitive tastes. If your new wants make you dependent upon society, suffer the penalty of being useless, and go to the Bicêtre there to die in wretchedness." His labours, however, were not as barren as he anticipated, for the principles of training and treatment which he adopted still remain, but of course have been further perfected by others, and by none more than by the late M. Séguin, whose treatise on idiocy and its treatment by the physiological method is still a standard work on the subject. In 1828 M. Ferrus organised an idiot school at the Bicêtre, and in 1831 M. Falret established a school for female idiots in the Salpétrière. Nine years later Messrs. Voisin and Leuret, physicians to the Bicêtre, organized the idiot schools in that great asylum. Here Séguin taught, and by various books and pamphlets has instructed the world in the method of his teaching. His mantle has fallen on a worthy successor in the person of Dr. Bourneville, who has much improved the school and is now doing excellent clinical and pathological work there. Meanwhile Guggenbühl, a medical man in practice in Switzerland, much moved by the sight of the miserable cretinous idiots so commonly found in the valleys of that country, in 1842 opened a school for them on the Abendburg, near Interlaken, his teaching being assisted by the pure mountain air which the children breathed. In the same year M. Saegert opened an institution for idiots at Berlin. In 1846 Dr. Kern established a school at Leipzig, and in the same year Dr. H. B. Wilbur opened at Barre, Massachusetts, a private institution, which he afterwards left to conduct the school at Albany, in the State of New York. Dr. Howe at the same time opened a school at Boston, Massachusetts, and now

[15] Ibid, p. 33.

the United States has numerous institutions in which close upon two thousand imbecile children are undergoing training. Dr. Howe was the man who imparted instruction to the celebrated Laura Bridgman, who was totally blind and deaf, and who had only a very indistinct sense of smell. The subject of idiot training had been advocated in England in 1819 by Dr. Poole of Aberdeen, who wrote an article on it in the Encyclopædia Edinensis. In 1847 Mr. Gaskell, who had just returned from visiting Séguin's Idiot School at the Bicêtre, wrote some articles in Chambers' Journal, giving an account of what he had seen. These articles attracted the attention of Dr. Andrew Reed, and as a result an idiot asylum was founded at Park House, Highgate, in 1848. Two years previously the first institution for idiots was established by Miss White, of Bath, in an ordinary residence in Walcot Parade, in that city. The Asylum at Highgate has developed into the well-known Earlswood Asylum for Idiots, of which Dr. Langdon Down was formerly superintendent, but is now the proprietor of a large private institution at Normansfield, Hampton Wick.

In 1850, Essex Hall, at Colchester, was opened as a branch of the institution at Highgate, and is now the Idiot Asylum for the Eastern Counties. The Idiot Asylum for the Western Counties was established in 1864, and the Midland Counties Asylum in 1866. I have not time to refer to the good work done in Scotland, Ireland and many parts of the Continent, and I pass on to 1870, when the Royal Albert Asylum for Idiots and Imbeciles of the Northern Counties was opened at Lancaster, under the superintendence of my friend, Dr. Shuttleworth. In 1875 the first pauper asylum for Idiots was opened at Clapton, London, under my own superintendence, the patients from which were removed in 1878 to the new and large institution at Darenth, in Kent, which is under my direction. Numerous as these asylums may appear to be, they are simply insignificant when compared with the number of idiots and imbeciles living in the United Kingdom. Excluding Scotland and Ireland, there are at the present moment more than 30,000, of whom a large number are improvable cases, and only a small percentage of these are taught and trained. More voluntary asylums should be built, and pauper asylums should be constructed all over the country, so that every county or borough should have its idiot as well as its lunatic asylum.

The pathology of idiocy is still in its infancy, but progress is being steadily made. Mierzejewski has written an important paper on the subject, which is also being worked at by Dr. Wilmarth, pathologist at the Philadelphia Training School for

Imbecile Children. He has collected about 100 brains, and has noted the peculiarities met with in each. One important conclusion has been reached, viz., that the convolutions of the brains of idiots and imbeciles often closely resemble those found in the brains of criminals. There is a tendency of the principal fissures to run into each other, forming what Benedikt calls a "confluent fissure type," which seems to be due to the cutting up of a comparatively simple series of convolutions by the formation of secondary fissures, or the prolongation of those usually existing beyond the normal limits, so that the surface of the brain is distinctly altered. Those who are interested in the pathology of idiocy may be referred to an article of my own which will appear in the forthcoming Dictionary of Psychological Medicine, edited by Dr. Hack Tuke.

Much improvement is gained by treatment; we have firstly, to strengthen the body and alleviate its defects; and secondly, to undertake the special training of the mind. Having placed the patient in as good hygienic conditions as possible, the physical training is commenced. The muscles, which are often wasted, have to be called into activity, and the want of co-ordination, due to the entire absence of the ordinary precision of muscular movement, has to be corrected by properly applied exercises. Contractures and paralyses are sometimes met with, and in such cases the general and special nutrition of the affected limbs must be increased by the application of electricity, massage and other measures. The automatic movements, due to want of the controlling power of the will, have to be replaced by others upon certain definite plans. Then, the muscular system being strengthened, the hands have less difficulty in performing any simple act, locomotion is improved, the dribbling from the mouth met with in low class cases is less evident, the eyes wander less restlessly, and listlessness and inertness to a great extent disappear. The moral training has to go on side by side with the physical and mental treatment. Obedience must be taught and efforts made to impart good temper and affection. There may be some difficulty in obtaining confidence and obedience at first, but the regularity of the institution, the example of others, and the general routine soon lead to marked improvement. Outbursts of temper often take place in epileptic cases, but strict attention to diet, suitable treatment, and enforced quiet by separation from others will usually suffice to calm the patient. The intellectual training in the lowest class of idiots commences by the cultivation of the senses, and as the tactile function is the most important, we begin by

educating the sense of touch. The senses of sight, hearing, taste and smell are awakened by a series of experiments, in every case proceeding from the simple to the complex, instilling ideas by the use of concrete forms and not by abstract notions. Having educated the senses, we proceed to higher branches of learning, and teach reading, writing, arithmetic, drawing, the idea of weight, the value of money, and a little elementary geography. When some progress has been made, instruction is given in tailoring, shoemaking, carpentering, mat making, gardening, &c., to the male patients, while domestic work and sewing prove useful for the females. Care should be taken to alternate the industrial with the purely intellectual training, and varied amusements have to be provided. By these means, thus shortly stated, all patients will be much improved, and many of those whose imbecility has been produced by a shock to their already unstable brain, will again attain a normal mental condition.

On glancing at the future, we are led to enquire whether there is any hope that the progress which has already been made in every branch of Psychological Medicine will be maintained. I am of opinion that there is good ground for such a hope, for as science advances, more and more will be known of the structure and functions of the brain. The labours of Gaskell have already thrown light upon the origin of the brain and nervous system, and those of Betz, Bevan Lewis and a host of others have given us much knowledge with reference to the structure of this important organ. Who, many years ago, would have thought that the brain would be laid open, and pus and tumours removed from it, as is now done from day to day? The labours of a noble band of workers have enabled this to be accomplished, and science looks forward to still greater conquests. The student has now the aid of the ophthalmoscope, the sphygmograph, the hæmacytometer, the hæmoglobinometer and the microscope, instruments which had not been invented in Hunter's time, while chemical research has put at our disposal numerous re-agents. To stimulate enquiry in this important branch of medicine, the Medico-Psychological Association has for some years given a prize, which is open to all Assistant Medical Officers of Asylums, for the best dissertation on any clinical or pathological subject relating to Insanity. Three essays were sent in last year, and two of these possessed so much merit that the examiners were obliged to award two prizes. As long as this spirit is at work in our younger brethren, we can with confidence look forward to future discoveries. Moreover the separation, which ought

never to have taken place, between psychological and ordinary medicine is gradually passing away, with equal benefit to the workers in both departments. The knowledge of Psychological Medicine should, however, be still more extended among all branches of the profession, so that those to whose lot it may fall to treat mental disease at the commencement, when remedial measures are most valuable, may be able to apply their knowledge with benefit to the patient and advantage to themselves. Enquiries into the causation of Insanity should be pushed still further; more attention should be paid to the laws of inheritance; endeavours should be made to impress upon those who are the subjects of this *damnosa hæreditas* the utmost importance of paying attention to the laws of health; and teachers should be warned against unduly pressing and overworking the brains of growing children.

Let us remember the old maxim, "ars longa, vita brevis," and whatever our medical path in life may be, let us see that we hand down the flaming torch of knowledge pure and undimmed to our successors.

"Let us then be up and doing
With a heart for any fate;
Still achieving, still pursuing,
Learn to labour and to wait."

So shall we humbly follow in the footsteps of our great master Hunter, whose life of devotion to medical science should be ever present with us. We cannot all be great discoverers, but we can conscientiously perform the duties that are given into our hands, and add our quota, however small, to the advancing stream of knowledge.

"Lives of great men all remind us
We can make our lives sublime,
And, departing, leave behind us
Footprints on the sands of time."

SESSION 1890-1891.

A Meeting of the Hunterian Society was held at the London Institution, on Wednesday, February 26th, 1890. Dr. STEPHEN MACKENZIE, President, in the Chair.

Mr. JONATHAN HUTCHINSON, Junr., was admitted an ordinary Fellow of the Society.

The President delivered the following address:—

GENTLEMEN,—I have very recently had an opportunity of addressing you at considerable length, but I do not think it would be quite fitting that I should assume the Presidential Chair without making a few remarks. I have already thanked the Fellows of the Society for the honour they have done me in electing me their President. I am fully conscious of the difficulties I shall have to contend with in succeeding so able and energetic a President as Mr. Clement Lucas, to whom the Society is deeply indebted for the influx of new Fellows, the improvements in procedure he has introduced, and the era of increased prosperity he has inaugurated. I shall be quite content to follow in his footsteps and help on the good work he commenced, and my long experience of the Society justifies the assurance that in so doing I shall have the assistance not only of the Officers of the Society, but of all its Fellows. You may be certain that no effort will be wanting on my part to maintain, and if possible increase, the success and usefulness of the Society.

I propose this evening to briefly consider the purpose and usefulness of Medical Societies. That such institutions are believed to be of value is evidenced by their continuity, their general prosperity, and progressive increase in numbers. Their

value is twofold : they are of immense service to the individual members, and an advantage to the community, for whatever helps forward the study of Medicine tends to lessen disease and death. The fact that Medical Societies exist and flourish, not only in our own country, but in every civilized community, proves that they supply a want of the medical profession. What that want is we will now proceed to inquire.

It is no exaggeration, or at least a very trifling exaggeration, to say that a medical man's education only begins when it is nominally completed. I do not mean to say he has learnt nothing—quite the reverse. Medical teaching in all our great schools is now in a worthy state, and the pupil is carefully trained in the principles and practice of all branches of medicine. What he has really learnt in the brief four years of his curriculum has been how to study disease, and true knowledge of disease can only be gained by close and intimate experience of it. Those who have been fortunate enough to hold residential hospital appointments have acquired some experience of the emergencies of practice, and gained some sense of the responsibilities which these entail. But even these, who are a minority, have been under the guidance and supervision of older and more experienced members of the profession, to whom they can appeal in cases of difficulty and doubt. It is when a man quits his medical Alma Mater, and enters upon practice on his own account, that his real education commences—when he has to battle singlehanded with disease. Now he is thrown on his own resources. He has to observe for himself, to think for himself, and to act for himself. He knows, probably, what mercy he may expect from a censorious public for any errors of observation, of judgment, or of treatment he may commit. Undismayed by this, if properly trained, he cheerfully accepts the responsibilities of his profession. But it is not a question to him of carefully and honestly doing his work under the Argus eye of an exacting overseer. His work claims his attention and his interest, and love of his work enables him to overcome its difficulties and endure its hardships. But for the love of the work, which requires the full development and exercise of his intellect, Medicine would have few inducements to able men to enter her ranks. State honours and accumulation of riches fall to few. Arduous and unwearied industry must be exercised before any professional success can be obtained. It is mainly the absorbing interest of his daily work, the unfolding before his eyes of the problems that have baffled earlier observers, the tracking of diseases to their lair, the fighting with Death inch by inch, and the snatching of a

threatened victim from his jaws, that are the great attractions of our profession, accompanied, in men of high purpose, by a feeling of usefulness to our fellow creatures.

As soon as a man is thrown on his own resources he experiences the need of association. He knows how easily error creeps into observations which are uncontrolled and uncorrected, and he wants to know if his own observations are accurate. Next, from the observations he makes, he draws certain new conclusions, and he requires to ascertain whether these are accurate and just. And lastly, when putting the theories he has formed of the nature and behaviour of disease into practice in treatment, he requires to know whether the effects he observes corresponds with the experiences of others, or whether he merely sees the facts through the spectacles of his wishes. All these his requirements are fulfilled by a Medical Society. Here he meets a number and variety of his own profession ; he meets men of his own age and standing, and can compare experiences and views ; he meets younger men trained in new habits of thought, and with the audacity of youth ; he meets with men older than himself, who have gone through similar phases of thought to his own, but whose ripened experience has corrected or confirmed their former ideas ; he meets with those whose branch of practice differs from his own, and who view the subject from a different standpoint. In these ways, he finds at a Medical Society exactly what he is in need of. His observations are confirmed or corrected and extended ; his inductions are criticised and any flaw discovered ; and the effects of treatment observed by himself compared with those of others. Thus at a Medical Society the individual worker gets exactly the assistance he requires, and loses the tendency only to see things in his own way to which the solitary observer is always exposed. I must not be understood to imply that medical work of the highest character necessarily emanates from Medical Societies ; but all individual scientific work must pass through the stages of examination and confirmation before it can be accepted as common knowledge. The scientific worker may from various causes prefer to put forth his observations and opinions in a book or other written communication. These will be criticised and examined by other writers, and ultimately accepted or rejected as they deserve. But this is necessarily a slow process, and it may take years before the necessary confirmation or refutation is obtained. At a Medical Society the necessary criticism is at once obtained, and a discussion clearly shows how a subject is regarded by a number of different minds. Moreover, at a Medical Society, the

exhibition of patients, of preparations of morbid anatomy, and of microscopical specimens, enable a subject to be illustrated in a manner which no written description can approach, for each member of the society can get the facts at first hand. A Medical Society has this further advantage, that it affords a wholesome stimulus to all who attend its meetings. We are apt to get into grooves which limit our views and fetter our actions. The work that others do and the remarks we hear at Societies stimulate all to fresh exertions, open up new ideas of disease, and introduce new methods of treatment.

Thus it has been that the majority of the most distinguished members of our profession, since medicine has had any claim to be a science, have been anxious to bring their best work before a medical and scientific society, previous to giving it to the world. It was so with the eminent anatomist, physiologist, and surgeon, John Hunter, after whom our Society is named. The preliminary sifting that communications have undergone before a society has often been of the greatest service in eliminating error, and in adding completeness to the views put forth. Further, there are many who have not the time or opportunity for communicating their knowledge by writing. These are often men engaged in extensive practice, whose experience, aid, and counsel it is most desirable to obtain. By snatching an occasional evening from their exacting work, these are able to help other investigators, whilst at the same time in return they themselves learn something new which helps them in their own work.

I must here take the opportunity of expressing my own indebtedness to medical societies in general and to the Hunterian Society in particular. This was the first Society I joined; here I read my first paper; here I first learned the pleasures and pains of official duties, and now having held every other office in the Society, I have reached the high position, of which I am greatly proud, of President of a Medical Society. I belong to, and have taken an active part in the work of, nearly every Medical Society in London, but to none am I more affectionately attached or more deeply indebted than to the Hunterian Society.

I have dealt with the advantages of Medical Societies to the profession. But, as I have already said, they are also of advantage to the community. Medical Societies, as we have seen, help forward Medical Science. The progress of medicine is a matter of moment to the whole community. The progress of medicine means the lessening of disease and the diminution of mortality. The lessening of disease means diminution of expense, and the saving of lives means the saving of a loss to the nation. These

lives, cured of disease and rescued from death, represent increased productiveness of the community and the augmented prosperity of the nation. The knowledge we individually and collectively gain is not kept to ourselves but is used for the public good. The greatest triumphs of medicine have been the discoveries of preventive medicine, and all effective legislation in Sanitary reform has been initiated and promoted by the medical profession. Whilst, therefore, Medical Societies are of importance to the profession, what helps forward their development and prosperity is repaid by a gain to the human race.

The Hunterian Society, founded in 1819, the second oldest of the existing general Medical Societies of London, has not been behind other societies in the good work it has done in the past, or is doing in the present. The detailed history of its foundation and early life, and of its work down to 1869, will be found recorded in the most interesting Hunterian Oration given in that year by Dr. Fotherby, one of our Trustees, formerly President, and for many years our Treasurer. The Society was established to supply the need felt of a Medical Society for the City of London and eastern parts of the Metropolis. The founders were men of high position, actuated by exalted intentions of promoting medical knowledge and benefiting humanity. Few societies can boast of a more illustrious list of office bearers, and some of the best work of the profession, from its earliest days down to last session, has been brought before this Society in the first instance. It has always remained a "City" Society. Meeting first at the rooms of the London Orphan Asylum, then in St. Mary Axe, it removed in 1821 to Aldermanbury, where it remained 14 years. When, at the end of this time, the rooms were wanted for other purposes, accommodation was found at the Congregational Library, in Blomfield Street, where the Society was located for 33 years. In 1866 the requirements of a railway company made it necessary for the Society to find a new home. This was a crisis in the history of the Society, its very existence being threatened by the difficulty in obtaining the necessary accommodation. In this emergency, the London Institution most kindly opened its doors to us. Here we have remained until the present time, and we owe a great debt of gratitude to the Managers of the London Institution for their continued hospitality and consideration. There is, however, a certain sense of insecurity about our permanency of residence here. This is not from any change in the enlightened policy of the Managers of the Institution, who have always felt "that the general interests of Art and Science are promoted by the protection and culture of any of its departments," but from

their own growing needs of space. You will all remember the "scare" we experienced a few years ago, when it was whispered that the Institution was afraid it could no longer accommodate our Library. Fortunately, by the efforts of some of the most active and public-spirited members of the Society, and the considerate indulgence of the Managers of the London Institution, the difficulty has been overcome.

The Library has always been an important feature of the Society. It was commenced in 1822, and in 1869 contained about 3,000 volumes, and had cost the Society, including binding and custody, not less than £3,000. The difficulties that have been experienced in the housing of the books have of late years discouraged its development. But believing in the great importance of a good library, readily accessible to the Fellows, my immediate predecessor recently took the matter up with his accustomed energy, and efforts are now being made to bring up our Library to the modern standard. It contains a great many old and valuable works, but it requires an immediate expenditure for modern works to make it adequate to the requirements of the Society. We cannot but feel, however, that our own increasing needs, and the increasing success of the London Institution, may bring about a condition of things which would prevent the requisite space being afforded to us, and thus a check be given to our growth and development. The value of property in the City is so high that we cannot look to our own efforts alone to secure for us a proper habitation.

It is in these circumstances that we feel we may legitimately appeal to the Corporation and great City Companies to come to our assistance. As I have shown, the influence of Medical Societies is potent only for good. Our Society has always been a "City" Society, and is the only medical society in the City of London. My predecessor, Mr. Lucas, has approached the Lord Mayor, by whom he was courteously received, and who has encouraged us to hope that our appeal may be favourably entertained. In the wealthiest city in the world there ought to be no difficulty in obtaining the assistance we are in need of. No blame attaches to the city magnates that our Society is in difficulty from the want of pecuniary aid or suitable habitation. It is our own fault that we have not applied sooner. But all respect the struggles of those who help themselves, and the past history of an individual or of a society must be the best evidence that it is worthy of assistance. The Corporation and City Companies have always offered encouragement to educational and kindred institutions. We hope that when our needs are known the assistance they can so readily afford will be given us.

A few thousand pounds would enable us to establish ourselves under a permanent roof, free from the anxieties of precarious existence, with ample room for our valuable library now and in the future, a suitable room for meetings, and perhaps, in course of time, a laboratory for scientific investigations. The City of London might thus obtain, in time, a medical institution with an honourable history and record of good work, of which it might be proud. This great city, so forward in all philanthropic work, would thus show that it was not backward in giving the assistance necessary to encourage a branch of science, that has for its aim the alleviation of human suffering and the prolongation of human life.

Dr. Hingston Fox shewed a case of "*Psoriasis of the Feet*," in a man, aged 59 years, who walked much. The disease had lasted at intervals for about fourteen years, and the symptom specially complained of was great tenderness of the heels; the epidermis there being thickened and hard.

Dr. Gilbert had met with several cases of tender feet, often very obstinate to treat; in one case small air pads gave relief. One subject was very neurotic, and much on his feet. An old surgeon had indicated the trouble to him as one that occurred to persons who had become thin, from absorption of fat under the os calcis. In gouty subjects such a tenderness was produced by small gouty deposits.

Mr. Tatham pointed out the association with flat foot, as in Dr. Fox's case, and had found that boots made with the arch well raised were helpful.

The President thought the case uncommon. Besides using means to lessen the pressure, some treatment for the thickened epidermis, which may probably have involved some nerve endings, should be tried, such as repeated applications of Unna's salicylic plaster.

Dr. Hingston Fox read a paper entitled "*Notes and Cases illustrative of Glycosuria*," as distinguished from Diabetes.

Case (1) was of a stout lady of 81 years, subject to severe recurrent eczema and erysipelas, sometimes combined,[1] also to gastric crises, resulting in diarrhœa, and to superficial glossitis, tinnitus aurium and double cataract. For five years past the

[1] See Report in Brit. Med. Journal, 1886, Vol. ii. p. 717.

urine had generally contained some sugar, sometimes as much as 5 per cent., the sp. gr. ranging from 1013 to 1029; the general health did not suffer.

Case (2) was a stout lady of 86, who fell ill two years ago with profound disturbance of digestion, and severe crises, attended with abdominal pain, vomiting, hard white stools, bile-stained urine, and glycosuria. The sugar was never in large quantity, scarcely exceeding 1 per cent., and the sp. gr. not above 1029. She wasted and nearly died of asthenia, but grey powder and magnes. sulph. always relieved her at the crisis, and she eventually recovered. She still, however, had slight crisis, the urine containing a little sugar.

In case (3) glycosuria was found once, during a sharp gastric crisis, in the subject of oxaluria and hypochondriasis, a gentleman, aged 55 years. Dr. Fox suggested that a glycosuric "storm" as illustrated by these cases, was one form of what are known as "bilious attacks." Dr. Buzzard and Dr. E. Long Fox would appear to include this condition in their recent description of nerve storms affecting the medulla oblongata.[2]

Case (4) was an instance of the glycosuria of acute febrile disease. A gentleman, aged 35, was struck down by severe broncho-pneumonia affecting most of the left lung, and threatening life. The urine was very copious, over 3,000 cub. cent. (110 to 120 ozs.) daily, urea was discharged in great quantity, 65 to 82 grammes daily (1,000 to 1,200 grains), and a little sugar was found on the second day, and traces as late as the fifth day of the disease. A fortnight later the urea had fallen to 22·3 gm.

Allusion was made to other cases of glycosuria, associated with pregnancy and the puerperal state, and some cases without any obvious causation. Dr. Fox discussed the causes of glycosuria, as detailed recently by Dr. Ord, and put forward the hypothesis that in many cases of diabetes the liver

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[2] Lancet, 1890, Vol. i., pp. 179, 345.

is overacting, glycogen is transformed too quickly, and these cases require opium or codeina; whilst in many cases of glycosuria apart from diabetes, and especially in those attended by the crises described, the liver is inactive, glycogen is insufficiently formed, and the sugar of the portal vein passes unconverted into the circulation; these cases are relieved by mercurials and saline purgatives. The state of the biliary function may be some guide to the activity of the liver. In conclusion, a ready method was shown of ascertaining about the percentage of sugar present, by comparing the colour assumed by Fehling's solution with a standard scale.

Mr. A. H. Tubby remarked on the occurrence of gastric crisis and the loss of tendon reflex, in diabetes, as in tabes. Mucin, as well as uric acid, may, under some circumstances, have a reducing power on Fehling's solution. Nervous exhaustion has an important influence in producing diabetes. In determining between transient and permanent diabetes, he thought the presence of urates and albumen would often help us.

Dr. Gilbert advocated Dr. Johnson's picric acid test for sugar.

Dr. F. J. Smith had met in the wards of the London Hospital with several cases in which transient glycosuria, for two or three days, had attended the opening of an empyema, or the tapping of ascites. In the latter case some vascular disturbance of the liver may be the cause.

Mr. T. R. Fendick remarked on the low specific gravity of the urine in Dr. Fox's cases. Where we get sugar with low specific gravity we may expect the glycosuria to pass off; where the gravity is high we may expect the sugar to be permanent.

Mr. F. R. Humphreys, however, described a case of glycosuria, in which the specific gravity, which had been 1030, had not for three years past exceeded 1012, the daily quantity of urine being 120–130 oz. This low density seemed no safe guide to duration.

The President remarked on the difficulty of the subject. He himself looked on glycosuria and diabetes as degrees of one condition, and both due to functional disturbance of the liver, a disturbance probably initiated by the nervous system. Bernard said "the brain misdirects the liver, and the liver misappropriates the food." If the liver is the starting point, what causes the disturbance there? a question difficult of solution. A cause of glycosuria not alluded to was an excess of the diastatic

ferment which exists in the liver and in the muscles, and which converts glycogen into sugar. This view receives support from the results of treatment: Carbolic, Benzoic and Salicylic acids, which have a distinct anti-zymotic action, are useful in diabetes, lessening the conversion of glycogen into sugar. He had had large opportunities of observing the relations of eruptions on the skin to diabetes, and he found that whilst in some skin cases a transient glycosuria, not of much importance, was present, yet in true diabetes skin eruptions were not at all common. During 15 years at the Skin Department of the London Hospital he only saw two or three such cases,—not including the slight skin irritation, especially affected by saccharine food, which attends diabetes.

A Meeting was held on March 12th, 1890. Dr. STEPHEN MACKENZIE, President, in the Chair.

Mr. ALFRED PARKIN was elected an ordinary Fellow of the Society.

Dr. C. R. WALKER and Mr. A. VORES were proposed as ordinary Fellows.

Dr. F. Charlewood Turner shewed a "*Heart*," in the wall of which was an extensive *Syphilomatous growth* with a necrotic central tract. The growth surrounds the infundibular part of the right ventricle, the channel of which is considerably stenosed by its projection a short distance ($\frac{3}{4}$ inch) from the pulmonary valve. It extends down the septum, which it traverses, forming an uneven projection into the cavity of the left ventricle. Incisions made in the anterior wall of the right ventricle near the septum, and into the projecting part of the growth in the posterior wall of the infundibulum, expose the firm yellowish necrotic central tract. The peripheral parts of the growth are white, resembling sarcomatous growth. The right coronary artery, which goes to the seat of the tumour, is patent and apparently healthy. But the left coronary is occluded by an adherent and decolourised thrombus, just beyond the point where the descending branch is given off. The walls of the

artery at the occluded part are much thickened, and the channel in consequence much narrowed. The wall of the right ventricle is also considerably thickened. There was a nodule of growth of the size of a large pea at the surface of the right testis, without a central necrotic area, but no other signs of syphilis were discoverable. There was, however, a history of syphilitic infection ten years previous to death. At the apex of the right lung, which was firmly adherent to the chest wall, was a fibroid tract, enclosing a small cavity with smooth walls, and at the root of this lung was a cretaceous mass of glandular origin.

The specimen was obtained from the body of a potman, aged 37. He had for some years been troubled with præcordial pain and palpitation with giddiness, from time to time. Four days before his admission to hospital he was nearly run over, and since then the pain had been continuous, and giddiness had come on whenever he moved. His pulse was slow, 52 on admission, and gradually became slower. Two days before his death, which occurred four weeks later, it was 44, and 40 on the day before he died in sudden syncope. A rough systolic bruit was heard at the base of the heart, and cardiac dulness extended to the right.

The President alluded to a similar specimen in the museum of the London Hospital. Although generally there is a long antecedent history of syphilis, yet rarely a gumma may be found in an early stage of the disease, as in a case cited.

Dr. F. J. Smith asked why these tumours were so rare in the heart, where all the blood was continually passing, whilst in the liver and elsewhere they were common.

Dr. A. T. Davies suggested that the lung condition also may have been syphilitic.

Dr. Turner, replying, said that all tumours were rare in the heart, there seeming to be some condition of heart muscle which rendered it inapt to take on such growth. Syphilitic disease of the lung commonly attacked the base rather than the apex.

Mr. R. G. Tatham shewed a specimen of "*Cancer of the Liver.*" The patient was a man, aged 61, a sailor, and had complained

of dyspeptic trouble, vomiting, &c., for about six months. Large cancer cells were at length found in the vomit. Pain was occasional, but comparatively slight throughout; late on a tumour became manifest. At the autopsy the portion of the organ adjacent to the pylorus was found adherent to the stomach wall, and the substance of the liver was here much broken down. A sloughy ulcer was formed, and dark offensive matter from the liver had by this means been vomited. About three-fourths of the entire organ was found to be infiltrated with cancerous growth; the primary growth was at the pylorus.

Dr. F. J. Smith alluded to the remarkable absence of pain in this case.

Dr. Gilbert had also met with a case where there was very little pain, and **Dr. Turner** referred to a case of gastric cancer under his care, where pain was absent.

The President remarked that the immunity from pain, and even from vomiting, sometimes found in cases of malignant disease of the liver and stomach, probably depends on the growth not pressing upon certain nerves. In the case detailed, which he had seen with Mr. Tatham, the gastric juice had access to the liver through the ulcer formed in the adherent part.

Mr. Tatham briefly replied.

Dr. Cotman shewed "*Kidneys* affected with *Puerperal Nephritis*." They were taken from the body of a plethoric woman, aged 40, who died comatose on the seventh day after delivery of an eight months' child, her tenth pregnancy. Frequent convulsive attacks had preceded delivery for about six hours, and two occurred within an hour after delivery. Hæmaturia was present for twelve hours, but on the second day the urine was free from albumen, and all appeared to be going on well until the seventh day, when two more convulsions occurred, and fatal coma supervened. The kidneys were large, bluish in colour, the pyramids being dark, and the cortex swollen and soft; numerous minute black spots were shewn on section. These appearances indicated recent early inflammation.

Dr. Herman considered the nephritis was in a very early stage. In a case to which he was called there was a question

of opening the abdomen; the patient died comatose, and large dark kidneys dotted with ecchymoses were found. Uræmic symptoms come on earlier in puerperal than in non-puerperal cases; there seems to be a peculiar liability to uræmia. The kidney condition is not a passive congestion as in long-standing disease of heart and lungs, where the kidneys are small and firm. He alluded to Grainger Stewart's description of acute atrophy of the kidney, which is apt to come on during pregnancy.

Dr. Turner, alluding to the disappearance of albumen from the urine prior to the onset of the coma, asked whether the latter could have been an independent condition determined by some absorption from the uterine surface.

The President spoke of the variable conditions of the kidney found after death from eclampsia. As to acute atrophy of the kidney, Dr. Murchison had shewn specimens strictly comparable to the liver affection; the organs were exceedingly shrunk. It was noteworthy that albuminuric retinitis in the puerperal state was recoverable from: he had seen cases. A certain degree of inflammation plus pregnancy sufficed to set up nephritis and retinitis. What was the arterial tension in the case described?

Dr. Cotman, in reply, said the case was unusual because the disease usually affects primiparæ rather than multiparæ. She was a plethoric woman with full arteries, but no signs of degeneration in them.

Mr. Bidwell shewed a specimen of "*Sebaceous Cyst of the Umbilicus.*" The cyst was of the size of a large cherry, and had been removed from a boy, aged twelve years, under the care of Mr. Lucas at the Evelina Hospital. A swelling had been noticed for two years and had gradually increased. The skin over it was not adherent, there was fluctuation, but no impulse on coughing; it was irreducible, but not translucent. It was thought at first to be either an old umbilical hernia, or a polypus, a remnant from the duct of the urachus. On microscopic examination it was found to be a sebaceous cyst.

Mr. Poland queried whether the cyst might have arisen from involution of the epidermis during the natural progress of cicatrisation at the umbilicus. He had shown at the Pathological Society a series of cases, in which such involutions took place at the seat of injuries.

Mr. Bidwell also shewed a "*Thyroid Gland affected with*

Tubercle." The specimen was taken from a boy, aged 5½ years, who died from acute general tuberculosis, the lungs being thickly studded with deposit. The gland was not enlarged, but there was a caseating tubercle the size of a large pin's head in the centre of the right lobe.

Mr. J. Hutchinson, junr., had seen a specimen taken from an animal in the Zoological Gardens.

Dr. Walter Fowler shewed a specimen of "*Hydatid of the Liver.*" In the right lobe was a large hydatid tumour about the size of the fœtal head at the eighth month. The cyst was full of fluid and daughter cysts, and had contracted adhesions only with the diaphragm. The specimen was taken from the body of a woman, aged 26 years, who died suddenly in syncope, apparently from pressure upon the inferior vena cava or right side of the heart. The cyst was evidently of old duration, but had given rise to no symptoms during life. There was also a suppurating sinus in the left loin, evidently kept open by some nodules of calcareous matter. For this she had been treated in Guy's Hospital at the age of 6 years, an abscess having been there opened. It was possible that this abscess might have been in reality a suppurating hydatid cyst.

Dr. F. J. Smith suggested that some small cysts might have found their way into the vena cava, and caused sudden death by pulmonary embolism.

Dr. Gilbert had met with a case of sudden death, in which an encephaloid mass was discovered under the diaphragm.

Dr. Fowler said that the lungs were carefully examined and found to be healthy.

Mr. J. Hutchinson, junr. shewed figures and microscopic preparations from a case of "*Myeloid Epulis*" which had recurred after excision ten months previously. The structure was that of typical myeloid sarcoma, with giant cells. In the microscopic slide, nodules of bone could be observed in the growth. It was commonly said that these tumours did not ossify, but he had found the reverse to be the case. The plum colour of the growth was characteristic.

Dr. Fowler had noticed bone formation in a good many such tumours.

Mr. J. Hutchinson, junr. also shewed a small "*Salivary Calculus*" taken from a woman, aged about 35 years, who was sent into hospital as a case of epithelioma of the side of the tongue. There was a hard mass, and as it was in the situation of Wharton's duct, he thought it might be due to a calculus, and on cutting into it he found it was so. A hard fibrous structure, about half an inch in thickness, surrounded the calculus, and the glands in the neck were enlarged.

The President had published a case in which the tongue protruded greatly, and the lad came to the hospital for glossitis. A body, the size of an ear of corn, was found suddenly underneath the tongue, it having escaped from Wharton's duct, and all the symptoms thenceforth subsided. Where swelling of the submaxillary gland is found rather than of the lymphatic glands, we should look for blockage. Dr. Dundas Grant shewed a case before this Society last year.

Mr. Tatham had seen several cases in a late stage.

Dr. Fowler had generally found that these calculi were discovered by accident, having given rise to no symptoms or complaint.

Mr. Hutchinson, in reply, alluded to other symptoms resulting in some cases, for example, acute ranula, caused by rupture of the duct into the bursa behind the calculus.

Mr. J. Hutchinson, junr. also brought forward microscopic specimens and drawings, illustrating a case of "*Paget's Disease of the Breast*" (inveterate eczema). He demonstrated the presence in the surface epithelium of a newly discovered parasite of the skin, the Coccidium oviforme. The coccidia have long been known to infest rabbits, producing in them a fatal disease of the liver, and have also been occasionally found in the intestines and liver of man. In 1889 M. Darier of Paris described their occurrence in Paget's disease, and the present case was the first in which they had been recognised in England. The patient had had the "eczema" around her left nipple for four years, and the supervention of scirrhus in the breast led

Mr. Hutchinson to excise it. The coccidia (or *psorosperms*) were found in great numbers, and were most easily demonstrated by means of soaking a scraping from the surface in liquor potassæ for some time, and then mounting the specimen in glycerine jelly. [The subject is fully discussed in the Pathological Transactions for 1890.]

The President said that the coccidia had also been found present in molluscum contagiosum and other sebaceous diseases.

A Meeting was held on March 26th, 1890. Dr. STEPHEN MACKENZIE, President, in the Chair.

Mr. Frank Quick was present as a visitor.

Mr. Frank Quick was proposed for admission as an ordinary Fellow.

Dr. Horrocks read a paper entitled "*Observations on Puerperal Fever with cases*," of which the following is an abstract. Under the term "Puerperal Fever" are grouped several distinct diseases. To change the name to "Puerperal Septicæmia" does not help us to distinguish these diseases one from another. All are agreed that the fever caused by decomposition within the uterus and accompanied by a foul discharge, is quite different from the disease in which there is no decomposition and no foul discharge. Where there is decomposition the disease is sometimes called "Puerperal Sapræmia," and the most important of the different affections included under the common term, but without a foul discharge, is a disease which from its fatal effects, its frequency, and its importance in relation to other diseases, might very well be termed "True Puerperal Fever." Puerperal sapræmia is a comparatively mild disease; the symptoms vary with the amount and duration of the absorption, and when the decomposing mass is cleared away the patient at once improves, so that the prognosis is good. In a true puerperal fever, there is nothing in the uterus

to clear away, and the patient, who as a rule begins to be ill on the third day following parturition, dies on the tenth, after one week of fever. Post-mortem examination mostly reveals some lacerations in the parturient canal; the uterus is more commonly affected than any other organ; and there is more or less local or general peritonitis.

Case (1)—Young lady, aged 21, married ten months, primipara, ordinary labour, feverish on the third day, died on the tenth.

Case (2)—Young lady, aged 23, attended by the partner of the doctor who attended case (1). Feverish on third day; suppression of lochia and milk. Chloroform administered and uterus explored. Nothing was found, and the walls of the uterus were scraped with a blunt curette, and the cavity was thoroughly washed out with a solution of perchloride of mercury. The patient had feverish symptoms for a week, and then recovered.

Case (3)—Primipara, aged 26. Rigors and fever soon after labour; died on the tenth day. No foul discharge, but suppression of lochia. This case was attended by a doctor who in a practice of twenty years had never before lost a patient from puerperal fever.

Case (4)—Primipara, aged 25. Her husband had been married before, and had lost his first wife from puerperal fever in her first confinement, in the same house. Fever on the third day, suppression of lochia and milk, tympanites, no foul discharge; very ill for a week, then recovered.

It is a well known fact that an accoucheur who attends post-mortem examinations, or dissects dead bodies, may carry puerperal fever to his patients. Some medical men appear to be particularly unfortunate in having cases of this disease, whilst their confrères practising in the same neighbourhood are free from them. Whether scarlatina can produce true puerperal fever has not yet been satisfactorily settled; many authorities believe that scarlatina always breeds true, and is still scarlatina

with its usual phenomena, even when affecting a woman in the puerperium.

The question as to whether a medical man should give up midwifery practice when he has a case of puerperal fever under his care is a very important one. In my opinion he ought certainly to attend no other midwifery case so long as he is in actual attendance upon a patient suffering from true puerperal fever, whether he makes vaginal examinations or not. After he has ceased his attendance he can make himself completely aseptic, and therefore fit to resume obstetric practice, in forty-eight hours, possibly in less; but that he can do so in forty-eight hours I have myself proved by performing Cæsarian section successfully, within forty-eight hours of having made a vaginal examination of a woman dying from true puerperal fever on the ninth day of the disease. Every practitioner ought to be very thorough in his application of antiseptic precautions in obstetric practice. It is well to dip the hands in a solution of perchloride of mercury (1 in 2,000), and keep them in it for five or ten minutes before making a vaginal examination. I do not think it is either necessary or wise to wash out the uterus and vagina as a routine practice in every case of ordinary labour. If an operation has been performed, such as the forceps, version, craniotomy, &c., then the uterus may be syringed out with advantage. When true puerperal fever has set in, curetting the uterine cavity with a blunt curette, and syringing with a solution of corrosive sublimate may be of advantage, especially if done early. I am not prepared to advocate removal of the uterus as a mode of treatment of this disease.

Dr. Gervis said that puerperal fever, *i.e.*, the septicæmia which follows labour, and that which follows miscarriage, commanded our close study. Thirty years ago we knew nothing about this fever; we were indeed confronted with these dreadful cases, and nothing had added more to the comfort of practitioners than the knowledge of their nature and treatment. It was a good practical point that in the great majority of cases you did not have septicæmia without local trouble. If you made

a thorough examination you commonly found some evidence of this near the outlet. It was necessary to examine the perineum very carefully in these cases; often a laceration was found to be much greater than it was thought, and quite sufficient to be the origin of septicæmic trouble. It must be treated with antiseptic solutions. Dr. Horrocks said that pelvic pain was absent in some cases, but this was not a safe guide as to the non-existence of local mischief. He had seen cases in which pain was absent, yet something was evidently wrong, and considerable parametric swelling would be found on one side. Pelvic inflammatory mischief of some form was the usual precedent to puerperal septicæmia. He had never tried curetting the uterus in this disease, but should think much care would be needed, using, of course, a blunt instrument, and it was by no means to be carried out as a routine practice. He agreed in not washing out the uterus, unless there were distinct reason to believe that septic matter was contained in it. But he had long made a practice of sponging the genitals with antiseptic solution, and ordering a daily antiseptic vaginal douche. He thought that by such means as these puerperal fever might be efficiently prevented from occurring in the future.

Mr. Percy Warner thought it difficult in practice to divide the cases into two distinct classes. In a case recently under his care there was some laceration of the cervix, a rigor on the third day, fever, but no fœtor, indeed she was never seriously ill. He subsequently found that a bathroom adjacent to the patient's room had some communication with a drain. If this was puerperal fever, it was in a very mild form. The most troublesome cases were those in which the uterus itself became inflamed, and here Mr. Lawson Tait's proposal to remove the uterus seemed worthy of support. But with plenty of quinine and opium one could often pull the cases through; he had given two grains of the latter drug every four hours.

Dr. Herman agreed with the positive aspect of the statements in the paper. There were a great many diseases included under the designation, puerperal fever, just as there were many diseases affecting wounds, for it was essentially a wound disease. Those disorders which affected the canal lower down were the most common. There might be sapræmia, even though the discharge was not foul; the absence of a stinking discharge was not a reliable sign. Koch shewed that some poisons were introduced into the system and eliminated, the symptoms produced being of a lesser kind than when, as in septicæmia, the germs multiply in the blood. True puerperal fever might be one of many diseases, such as diphtheritic condition of the wounds,

septicæmia or pyæmia. A solid mass might need washing out of the uterus, although there be no fœtid discharge. If medical men have a run of puerperal fever cases it must be because they are not so perfectly cleanly in their work as others are; antiseptics are only a form of surgical cleanliness. Semmelweiss' name deserves to be held immortal in the history of medicine for his enlightened views in this respect, yet he knew nothing of germs. In the General Lying-in Hospital only one fatal case of septicæmia had occurred during many years since the sublimate had got fairly into use, and only 20 per cent. of cases had any feverish symptoms at all. Salufer was tried during a limited period, but it was not so effective. As to the connection with scarlatina, the evidence of cases in which septicæmia had been produced was not conclusive. There was evidence on the other side. Thus when outbreaks of scarlatina occurred in Lying-in Hospitals where antiseptics were used, no septicæmia followed, nor was the proportion of fever in the hospital in any way increased, excepting by the actual scarlatina cases. Again, the death-rate from puerperal fever was not increased in the community at large during epidemics of scarlatina. He agreed with Dr. Horrocks in his rules as to the attendance of other labours whilst attending a puerperal case. Routine syringing of the uterus was undesirable, but the vaginal syringe immediately after confinement was useful, and was scarcely noticed by the patient.

Mr. G. J. B. Stevens was glad that the tendency to envelope the subject of puerperal fever in a cloud of obscurity was passing away. It needed truthful and candid dealing. We must safeguard ourselves against vicious remarks from an ill-informed public. The public should be told that all the surroundings of the lying-in woman should be scrupulously clean. During twenty years of practice he had had of course cases involving a good deal of trouble. He now used the perchloride for cleansing the hands.

Mr. F. Quick drew attention to a series of cases in Yorkshire recorded last year, in which a practitioner suffering from chronic otorrhœa was himself the source of infection. An American doctor, mentioned by Dr. Playfair, after ceasing to attend cases for two years, had a fatal case immediately on resumption: ozæna in himself was the cause. A case under his own care had yielded to careful syringing.

Mr. A. H. Tubby had found in Halle, Leipsic, &c., an elaborate system in use, students and others washing their hands with hard soap, scrubbing the nails, washing with ether, and steeping for five minutes in perchloride solution. Some of

the students suffered from mercurial poisoning in consequence, but the results to the women were excellent.

Mr. G. Borlase Hicks did not remember a case of puerperal fever without the discharge assuming a peculiar and fœtid smell. Puerperal cases were not always susceptible to scarlet fever infection; thus he had once, when himself commencing to develope scarlatina, attended a labour, and the patient recovered well, not taking the disease.

Dr. Horrocks, in reply, said he had only objected to the term septicæmia as involving a theory. Pelvic lesions were, he agreed, present in the majority of cases, indeed slight lacerations occur in almost all cases of labour, and often there may be mischief overlooked in the perineal veins, following a laceration. In the cases he denoted *true puerperal fever*, one did not commonly get pelvic effusion. He used the curette with the view of getting rid of germs and exciting the lochia, the uterus having been already found free of clots or placental masses. As to the scarlatinal poison, he thought there might perhaps be some variation in its effects when entering through a different channel. He had found antifebrin very useful in puerperal fever.

A Meeting was held on April 9th, 1890. Dr. STEPHEN MACKENZIE, President, in the Chair.

Mr. Alfred Parkin was admitted an ordinary Fellow.

Mr. Arthur Vores and Dr. C. R. Walker were elected ordinary Fellows.

Mr. Bidwell shewed a case of "*Congenital Dislocation of both Hips*," with Lateral Curvature of the Spine. The patient, a female child, aged 6 years, was in the Evelina Hospital, under Mr. Makins. She had fallen out of bed when 6 months old, and projection of one hip had been noticed since then. The child had never walked, and was sent to the Hospital as a case of infantile paralysis. There was no difference in the length of the two limbs, but each great trochanter was $1\frac{1}{2}$ inches above Nélaton's line, the head of the femur lying on the dorsum ilii. The limbs were slightly flexed, but movements were free;

knee-jerks present. The rotation of the vertebræ was considerable; there were some signs of rickets. Weight extension (5 lb. weights) was being applied to both legs; later the child will be taught to walk with a go-cart.

Mr. Poland remarked on the features of the case.

Dr. Cotman shewed an infant, aged about 6 months, with "*Congenital Nystagmus*," the movements being vertical in direction. The infant was plump, the eleventh child of a healthy woman, but the father was a heavy drinker, and had strange delusions, not like those of delirium tremens; one of his attacks occurred about the time of the child's conception. Vision and intelligence appeared to be unimpaired. Dr. Cotman was inclined to attribute the condition to a local chorea.

The President had seen many cases of congenital nystagmus, and had no doubt of its central origin; the co-ordinating centre governing eye movements was affected. Miners get nystagmus whilst working underground; when they are above ground it disappears. An instability or malnutrition of the centre would exist in the present case.

Dr. F. J. Smith and **Dr. Hingston Fox** alluded to cases where blindness co-existed.

Mr. F. R. Humphreys spoke of two cases, one in a family in which lunacy had occurred, another where tubercular meningitis had been present.

Dr. Cotman also shewed a case of numerous "*Rheumatic Nodules*" about the hands, elbows and knees of a boy, aged 16 years, who had had Rheumatic fever two years ago. Well marked mitral disease and hypertrophy of the heart were present; temperature just below 100°.

The President referred to the re-description of this condition by Drs. Warner and Barlow at the International Medical Congress in 1881. The prognosis in these cases was grave; an example recently in the London Hospital had run a rapid and fatal course. The condition was almost always associated with very grave heart disease, and generally occurred in children. The nodules go away and appear from time to time; their position is usually over tendons and parts less nourished, the site also largely dependent upon

pressure or friction. Sir Dyce Duckworth and himself had shown cases in which such nodules appeared to be connected with syphilis; and nodules were observed in a gouty subject of the nature of tophi, but much resembling the rheumatic nodules. The structure of the latter had been found by R. W. Parker to consist of very vascular fibrous tissue, similar to that of the vegetations upon the cardiac valves.

Dr. F. J. Smith had found the condition a rare one. Out of hundreds of cases of acute or subacute rheumatism at the London Hospital he had not seen more than three or four.

Mr. F. R. Humphreys had observed a case in a boy, aged 19, who had never had acute rheumatism nor heart disease, but had chronic muscular rheumatism. There were nodules in the neck, over the hips, and over the ribs. Iodide of potassium ointment removed some of them.

Dr. Langton Hewer submitted that where there was no history of acute rheumatism, such grave import was not to be attached to the symptom.

Dr. Dundas Grant shewed a case of "*Papilloma of the Larynx*" in a girl of 8 years, who had for four months suffered from loss of voice and attacks of dyspnœa. A large papilloma was found, its exact seat being difficult to ascertain owing to the size of the growth, but it was defined to be of an hourglass shape, and partly above and partly below the glottis. Several attempts were made to remove the growth by the snare, and enough was obtained to submit to microscopic examination. The larynx became very irritable after repeated attempts, and the patient was put to rest with cold Leiter's coil applied to the part. Then Mackenzie's forceps (modified) were used, and with some success; this was repeated at intervals, and the voice returned, the dyspnœa also disappearing. Thus a good part of the growth had been removed, and a practical cure effected, although considerable sessile papilloma remains on the left vocal cord. This was demonstrated to the meeting. The difficulties in operating on a little child are not small.

Mr. T. Mark Hovell described the case of a boy, aged $3\frac{1}{2}$ years, whose larynx was so choked with papilloma that he was obliged to perform tracheotomy. Anæsthetics were found necessary in dealing with the growth, which was entirely

removed, the voice being restored, and the tube afterwards removed (see p. 135). He had recently a woman under care in the London Hospital, from whom a similar growth was successfully removed. He never now used the snare, but always Mackenzie's forceps, spraying with a solution of cocaine,—5 per cent. for a child, stronger for adults.

The President asked, what explanation could be given for young children getting these growths? were they the result of chronic inflammation? do young children functionally abuse the voice or strain the larynx in coughing?

Dr. W. Fowler had examined the growth microscopically, finding it to be a typical papilloma; when multiple these tumours are nearly always congenital, when single they are not so.

Dr. Grant, in reply, said he believed the tumours to be much more frequent than was generally supposed, and that children died from the effects of them when unsuspected. He could suggest nothing as to their cause. In the small calibre of a child's larynx a small growth might produce grave symptoms, but much improvement was often found as the larynx rapidly enlarges with the child's growth. He thought the sponge useful in some cases, but the forceps more generally; the spray he feared to use on account of the uncertainty of dosage. His own case was intolerant of cocaine.

Dr. W. Fowler exhibited a case of "*Ectopia Testis Cruralis*" in a lad, aged 17 years. Over the left saphena opening was a superficial and loosely fluctuating tumour, about the size of a split Tangerine orange, and at its lower part the testicle could be plainly detected with its spermatic cord. There was no impulse on coughing, and the testicle was irreducible. Above the tumour and separated from it by a constriction was an ill-defined fulness, parallel with, and reaching up to, Poupart's ligament. There was here very doubtful impulse on coughing, but, if present, it was not that characteristic of bowel. The spermatic cord disappeared behind this fulness and the ligament. When the patient was lying down, a certain amount of fluid could be displaced from the tunica vaginalis into the fulness above it, as though the processus vaginalis were not obliterated. The displaced testicle was small, tender, and possessed testicular sensation. The left side of the scrotum was shrivelled

and empty; the right was fully developed and contained the right testis, which was normal and in proper position. The lump had been noticed for about ten years, during which he had worn a truss, in the belief that it was a hernia. Patient states that the lump partly disappears on lying down, that the only inconvenience has been a good deal of aching, especially after prolonged exertion, and that it has varied in size lately. He is of the Jewish persuasion, accustomed formerly to athletics, and apparently in good health, except for chronic constipation. Excision was recommended, on account of the risk, firstly that a hernia might follow, and secondly, that the gland might take on sarcomatous growth.

Mr. Rivington had never met with such a case. The testicle seemed somewhat below the femoral canal. There was apparently a little hydrocele, and higher up another swelling, apparently a hydrocele of the epididymis. As to operation, he would determine under an anæsthetic whether the testis was physiologically active, as indicated by its fair size and consistence; in that case he would leave it alone, unless the patient found it very inconvenient, and wished for its removal.

Mr. Poland questioned whether the hydrocele were not of the congenital variety, and asked if Dr. Fowler had been able to reduce any of the fluid. He would advise excision, glands in an abnormal position being so apt to take on malignant growth.

Dr. Fowler, replying, believed the hydrocele to be infantile in nature. The deformity had not interfered with sexual appetite.

A Meeting was held on April 23rd, 1890. Dr. STEPHEN MACKENZIE, President, in the Chair.

Dr. Arthur Davies shewed three cases of "*Bronchocele,*" viz: two sisters and a niece, all born at one village in Devonshire, as well as a fourth case, unrelated, but living in the same village, and for three months in the same house. The eldest sister had observed the swelling for three years. Their mother and one brother had died of consumption; the niece was the daughter of this brother, and now aged 15 years.

The President observed that the tumour in the first case seemed to be in part fibrous, in the others to be purely glandular. As to causation, experience strongly pointed to an endemic influence, rather than one dependent on consanguinity, although there may be an inherited tendency.

Mr. Mark Hovell said that in the treatment of simple glandular cases, the internal administration of iodine answered well; given with hydrochloric acid and glycerine it was not unpleasant, beginning with five minims and increasing to seven or more, three times a day. When the tumour was more fibrous, injection with Tinct. Iodi m.v. to viii. was the best treatment. He had used these injections thousands of times, and only once saw any mishap, a small abscess forming from the iodine getting into the cellular tissue of the neck; no serious result had followed. He would fear that in the first case the gland was too hard for injection, and would leave it alone, unless it became more inconvenient, when he would excise the isthmus and perhaps one lobe. Cystic goître was of course excluded from his recommendations as to treatment.

Dr. Hingston Fox remarked on the mysterious pathology of the thyroid gland, and referred to a case of subacute inflammatory enlargement of the gland in a woman he had brought before the Society, and to cases he had seen of enlargement of the gland at the catamenial epochs. He asked what was the condition of the menstrual function in the cases shown.

Dr. Davies replied that the two sisters were regular in their catamenia, the elder suffering some pain; the niece had never menstruated, and the fourth case had always been irregular, and the menses had ceased for six months past.

Dr. Herman read a paper entitled "*Cases of Amenorrhœa from Mental Shock and with mental depression.*"[1] Several cases were narrated, in which shocks, such as the death of a relative or a family quarrel, were supposed to have caused cessation of the menses, but he believed that the real condition in these cases was one of mental depression akin to melancholia, and of defective nutrition. The uterus showed either some atrophy or no apparent change. The condition was a common one. In some of the cases recorded, the Weir-Mitchell treatment, massage and galvanism had proved effectual in restoring the

[1] See Lancet, 1890, vol. ii, pp. 764,810.

flow ; these means, with hospital life, are the best available for the poor. Those who can obtain change of air, with exercise, food and tonics, attain a like result. Should the uterus be treated locally ? If the cessation be due, as he believed, to the depressed state of the system, there could be no advantage in making the uterus bleed. He saw nothing to be gained by local treatment. He would ask, finally, whether there were any cases of amenorrhœa due to mental shock alone, not accompanied by melancholic symptoms?

Dr. Hingston Fox inferred that the amenorrhœa was in these and other cases beneficial, nature saving the debilitated system from the loss it would have incurred, just as in many cases of anæmia. He was glad of Dr. Herman's authority for relying on general and not local treatment in such cases.

The President, recurring to the traditional views on this subject, mentioned that vicarious menstruation used to be universally stated in text-books as a cause of hæmoptysis. He had never met with a case of amenorrhœa after shock, but did not see why it should not occur, just as a shock to the liver may cause jaundice. He asked what was the state of the menstrual functions in melancholia, as observed in asylums.

Dr. Herman agreed that the amenorrhœa was beneficial. This condition was the rule in pronounced melancholia. The cases he had brought forward occupied a half-way house to melancholia. He accepted the traditional statements that mental depression does cause amenorrhœa, but complained that the student was told nothing as to the class of cases or the treatment. Some said, it is the proper thing to stimulate menstruation, else they may go on to insanity. He had never seen a case of amenorrhœa from mental shock pure and simple.

Mr. Rivington shewed a case of "*Stricture of the Œsophagus.*" A labourer, aged 61 years, was admitted into the London Hospital on Dec. 22, unable to swallow solids, and liquids only a teaspoonful at a time. The man was in excellent condition, and there were no signs of syphilis, or other apparent cause. A bougie passed fourteen inches, and was then stopped. The stricture was diagnosed as malignant. The use of bougies was persevered with, until on January 3rd he passed the smallest tube; the next size on the 4th, and he could then swallow

better. At length he could take bread and butter, and he was discharged on the 17th, passing a No. 12 bougie with a bulbous end. At the present time he could get in a No. 20, and is doing his work. He lost one stone in weight during the nine months preceding December, but has gained since January.

Mr. Poland asked whether the breath was fœtid, and what treatment was proposed for the future?

In reply to **Mr. Bidwell, Mr. Rivington** said there was no hæmorrhage on the passage of the bougies.

The President thought the disease was malignant, despite the temporary improvement. A patient with malignant disease may gain flesh, even while local disease is increasing in size. In cases where a stricture has been so tight that no liquids can be swallowed, you can nearly always pass the finger through the stricture after death, when spasm and congestion, the two active elements, are absent. In this case dilatation had occurred under treatment, but in the absence of syphilis or a history of swallowing corrosive fluid, it was, at his age, almost certainly malignant.

Mr. Rivington narrated a second case, now in hospital: an emaciated woman, aged 55 years, with no particular family history. She dated her swallowing difficulties from an accident which took place in a water closet, when she was thrown to the floor. Bougies were faithfully tried for a month after admission; once only, a No. 11 was passed into the stomach. She could hardly swallow anything and was constantly vomiting. On March 1st Mr. Rivington performed Gastrostomy, making an incision two fingers' breadths from the margin of the thorax, and cutting through the rectus vertically. He found the stomach under the liver, much contracted, and looking like small intestine; a mass of cancer at its cardiac orifice. The stomach was then sewed to the abdominal wall. She was fed by enemata. Two days later the stomach was opened, and a small glass tube introduced and left in, through which peptonised fluids are injected. She constantly vomits foul-smelling stuff from the stomach. One stone had been lost in weight in three weeks before the operation, $5\frac{1}{2}$ lbs. in seven weeks since its performance.

The President congratulated Mr. Rivington on his success. The disease, however, was progressing, and the fear was that ulceration would extend into important neighbouring organs. Would it be well to wash out the œsophagus with antiseptic fluid to try to obviate ulceration?

Mr. John Poland said it was Mr. Howse who first introduced the plan of operating in two separate stages. He would advocate feeding the patient through a fine tubular needle introduced into the stomach immediately on exposing it. It was usual to find that the opening had been made near the pylorus, it was therefore desirable to keep as near the cardiac end as possible.

Mr. Rivington replied that in this case she was doing well with nutrient enemata, and he had not thought it well to feed by the aspirator needle.

Mr. Bidwell read a paper on the "*Treatment of Erysipelas by Hypodermic Injections*," a method introduced by Hüter about ten years ago, but never, he believed, employed in this country. Three minims of a five per cent. solution of carbolic acid were injected at several points one inch apart, in the apparently healthy skin, half an inch from the red spreading margin, covering the whole with cotton wool. This had been done in five cases of children with most favourable results. In all the rash had been extending, and it disappeared in from one to two days after the injection. In two cases the children were drowsy and did not feel the operation; the others were anæsthetised. There were no symptoms of carbolic acid poisoning: only in one case was there any local suppuration, a small abscess forming on the scalp. The severest case was that of a child, aged 2½ years, admitted into hospital with vulvitis. The temperature rose steadily to 104° F.; there was vomiting, redness and œdema, commencing below the eyes and invading much of the scalp, with a rapidly spreading edge. The child was almost unconscious and refused food. After the injection had been used, general improvement was quickly manifest. The relation of the treatment to the pathology of the disease was then discussed, and it was stated that the streptococci, which are reported to abound in the skin affected

with erysipelas, and which convey the disease to rabbits by inoculation, are no longer infective when mixed with solutions of carbolic acid or corrosive sublimate. The author claimed that, whilst the natural tendency of the disease is towards cure, the hypodermic treatment shortens its duration, and thus lessens the danger of infection.

The President had never seen the treatment employed, although he had read much of it. Were all the cases traumatic or all spontaneous? the traumatic being generally less tractable. Would an adult submit to the treatment? He would like to see it tried in erysipelas ambulans, a severe spreading form, going on for weeks and weeks, with a temperature of 105° and 106°. In a case of this kind under his care some years ago, many kinds of treatment were tried without any effect, and eventually the disease died out, the patient recovering.

Mr. John Poland considered the series of cases of great interest and value, especially as regards the germicidal power of the remedies employed in this way in erysipelas. Subcutaneous injections of the same substances, viz.: carbolic acid and perchloride of mercury, as well as of others, iodine and salicylic acid, had all been extensively employed in the treatment of anthrax, with varying success. It was important to note the experiments of Mr. Watson Cheyne on rabbits, proving conclusively the antagonistic action of the erysipelas upon the anthrax virus, and it could not therefore be supposed that the germicidal power of these drugs was identical in these two diseases. More information was needed to determine the peculiar action of each.

Mr. Bidwell said that three of his cases were traumatic (bursa excised from the knee, ulcer of leg, abscess incised), whilst two were idiopathic (eczema, eye discharge).

A Meeting was held on October 8th, 1890. Dr. STEPHEN MACKENZIE, President, in the Chair.

Mr. Frank Quick was elected an ordinary Fellow.

The President, in the course of a few opening remarks, announced the resignation by Mr. Rivington of the office of Treasurer of the Society, and the appointment of Dr. Charlewood

Turner to hold the office until the next Annual Meeting. He alluded to the Clinical and Pathological Evenings as a new departure in the work of the Society, and one of great value to those engaged in practice. The Society might well extend its scope in the direction of microscopical and histological research. He referred to Dr. Ruffer's recent researches on the two kinds of leucocytes or phagocytes in the tonsil, microphages and macrophages. Any one who has not seen leucocytes on a warm stage under the microscope can have little idea of the processes which are taking place. Whilst it is no doubt difficult for those engaged in general practice to give time to such work, yet we may remember the example of Dr. Lockhart Clarke, who in the midst of busy practice, carried out those researches which laid the basis of science in his own department.

Dr. Pye-Smith read a paper on "*Some Points in the Prognosis and Treatment of Cardiac Disease.*" [1]

He began by a brief reference to the *functional disorders* of the Heart, of which the prognosis depends upon their recognition, and the treatment on the discovery of their cause.

Passing to *primary diseases of the cardiac walls*, he commented on the large space they occupied in medical writings previous to the discovery of auscultation, their subsequent neglect, and the undue reaction which at present, according to some authorities, makes valvular lesions seem almost unimportant compared with the existence of dilatation, hypertrophy or degeneration. After referring to the small group of cases depending on cardiac hypertrophy from overstrain, especially in children and young men; to those of rapid dilatation, from weakening of the muscular walls, after fever, particularly diphtheria, scarlatina and enteric, and from increased blood-pressure in acute nephritis; he discussed the prognosis of primary fibroid hypertrophy, and of fatty degeneration. With respect to the latter, he remarked that our means of diagnosis are very imperfect. When diagnosed during life, it is often sought in vain in the dead-house, and when discovered there, we may have seen no symptoms of its presence during life. True fatty metamorphosis

[1] See British Medical Journal, 1890, vol. ii. pp. 1345,1422.

of the cardiac fibres is not common as a complication of valvular disease, and is most often a result of extreme anæmia or of poisoning by phosphorus. Fatty overgrowth, or hypertrophy of the adipose tissue under the pericardium, is more frequent and probably more dangerous.

The prognosis and treatment of disease of the cardiac walls is, in the great majority of cases, that of secondary hypertrophy or dilatation accompanying either valvular disease, or chronic Bright's disease or bronchitis, or other causes of primary pulmonary obstruction.

In each of these conditions the physiology of the hypertrophy or dilatation is the same. Both processes are the result of increased blood-pressure, and exactly correspond to the dilatation and hypertrophy of the bladder from stricture, of the stomach from pyloric obstruction, or of the colon above a cancerous growth. The obstruction in the case of Bright's disease is in the systemic arterioles, and the left ventricle therefore feels the first stress and hypertrophies to compensate it; but latterly it often gives out and becomes dilated, with all the results of cardiac failure, including the dropsy of gravitation. When the mitral valve is the seat of obstruction, the left auricle hypertrophies and dilates, with consequent congestion of the lung, dyspnœa and frequent hæmoptysis. If the primary obstruction is in the pulmonary capillaries, the right ventricle and auricle dilate, and the former hypertrophies.

In each case, with regard to prognosis, the hypertrophy is compensatory of the obstruction in front of it, and is therefore conservative. The dilatation indicates that the muscular walls of the cavity are beginning to yield to the undue pressure of the blood; and this yielding is the beginning of the various hydraulic results which assimilate the last stages of such different primary diseases as aortic incompetence, mitral stenosis, adherent pericardium, cirrhosis of the kidneys and emphysema of the lungs. In each case, with regard to treatment, our object

is to feed the muscle, to regulate its rhythm, to lengthen the cardiac interval, to diminish the systemic work, and to relieve from time to time the overpressed heart by diuretics and purgatives, or if needful, by direct abstraction of blood.

Prognosis of Ulcerative Endocarditis.—It is unnecessary to insist upon the great danger of this condition. It is, in fact, not a mere mechanical obstruction to the circulation, but a form of internal pyæmia, in which micrococci and the chemical poisons which accompany them, are continually being deposited in the most favourable possible situation for distribution over every part of the body by the blood stream. But just as the surgeon meets with occasional cases of chronic and articular pyæmia, like those described by Sir James Paget, so we meet with exceptional cases in which some difference in the quality of the infection, or some increased power of resistance in the tissues, robs the disease of what Dr. Osler calls its malignancy. One such case came under my observation in May, 1883. A young man was admitted into hospital with valvular disease from previous rheumatism. To this was added recent acute ulcerative endocarditis, shown not only by the high and variable temperature and by the changing character and locality of the murmurs, but also by the occurrence of embolism, first in the radial artery, and then in the dorsalis pedis. In the former case we had a striking illustration of the effect of a septic embolus, in causing acute softening of an arterial wall and expansion under diminished resistance to the blood pressure, for an acute aneurysm formed in the space of a few days in the obstructed artery. This patient lost his fever, gained his appetite, and after a time insisted upon leaving his bed. Finally, he left the hospital with the physical signs of the original valvular disease of course remaining, but with no symptoms of an active ulcerative process. His temperature was normal, he had gained flesh, and was eating and sleeping well.

Chronic Valvular Sclerosis.—Passing now to some points in

the prognosis and treatment of what are the more frequent and most important of cardiac diseases—those of the valvular apparatus—the first question is, what is the relative prognosis of the several anatomical lesions, circumstances being equal?

Lesions of Tricuspid Valves.—Tricuspid stenosis is almost always a complication of a similar contraction of the mitral valve, and I do not know whether it increases or diminishes the effects of the latter.

Tricuspid regurgitation is always secondary to valvular disease of the left side or to chronic obstruction in the pulmonary capillaries. Its existence is a sign of serious disease, but does not add to the gravity of the case, and may be regarded rather as a conservative effect in distributing increased venous pressure and allowing relief by anasarca.

Lesions of Pulmonary Valves.—Pulmonary, or, as I should prefer to call it, "dextro-sigmoid" regurgitation is extremely rare, except as the result of ulcerative endocarditis of both sides of the heart, and it can scarcely add to the very grave prognosis of that disease.

Pulmonary, or dextro-sigmoid stenosis is well known as a congenital lesion—either a true malformation or the result of intra-uterine endocarditis; and its presence may be recognised both by symptoms and physical signs during life. The prognosis depends upon the narrowness of the opening and the condition of the ductus arteriosus and foramen ovale. In extreme cases life cannot be maintained long after birth. In the more favourable ones the patient may grow up with more or less of cyanosis, dyspnœa on the least exertion, liability to cold hands and feet, and to attacks of bronchitis if he spends the winter in England. The longest case I have known of well-marked morbus cæruleus from this cause was that of a young man who lived to about the age of 25, but I have heard of longer ones.[1] Besides the

[1] In the slightest form this malformation may allow life to be prolonged till over 50 years of age, as in a case recently under the writer's notice.

immediate effects of imperfect aëration of the blood, there is no doubt that these patients are particularly liable to death from tubercular disease of the lungs.

Lesions of Aortic Valves.—Of the valvular diseases of the left side, it is generally admitted that aortic regurgitation is the most dangerous, the shortest in duration, the least remediable, and the most liable to sudden death; and that aortic obstruction is, other things being equal, the least severe in its symptoms and dangerous in its results. There is, however, considerable difference between an aortic lesion, the result of rheumatic fever in a young and otherwise healthy subject, and the same mechanical alteration when it occurs as the result of chronic atheromatous arteritis, with extensive degeneration of the arteries. In the latter case aortic stenosis, though causing slight symptoms, may lead to sudden and fatal syncope.

Lesions of Mitral Valves.—The prognosis of chronic mitral disease is recognised by all authorities as more favourable than incompetence, and less favourable than obstruction, of the aortic valve. According to Dr. Peacock, Dr. Wilks, and Dr. Bristowe, while aortic obstruction is the least serious of valvular lesions, stenosis of the mitral valve comes next, and regurgitation is far more serious, though less so when affecting the mitral than the aortic orifice. Other writers, however, have regarded mitral stenosis as a graver defect than incompetence.

Perhaps the explanation of the difference of opinion lies in the following considerations: Mitral stenosis is in adults more frequent than simple incompetence; but a large number of obstructive cases first come under notice when regurgitation has also taken place, and the physical signs of the primary lesion are then not always recognised. Again, we may meet with well-marked cases of simple mitral stenosis accidentally in persons who seek advice for some other complaint. Such cases go on for a long period, and may be considered as of better prognosis for the duration of life than cases of regurgitation;

but it must be remembered that they are more liable to be cut short by sudden death than when regurgitation has taken place.

Uncomplicated primary mitral regurgitation is probably, of all valvular lesions, least liable to the danger of fatal syncope; but it is more speedily followed by pulmonary obstruction, general venous engorgement and anasarca. Nevertheless, when the symptoms are once established they are more amenable to treatment, than when they occur in the later stages of mitral stenosis or aortic incompetence. If we were to select a case of disease of the heart as an instance of the power of medical treatment, we should, I think, take that of a patient water-logged and nigh to death from the effects of uncomplicated mitral regurgitation. When, as is frequently the case, stenosis of the valve after perhaps many years' persistence becomes complicated with increasing regurgitation, the symptoms resemble those of primary mitral incompetence, but the effect of active treatment is far less satisfactory.

Whatever the locality of the valvular lesion, what was remarked of aortic stenosis is generally applicable: that other things being equal, the degenerative, often atheromatous, chronic process which belongs to middle and later life produces more severe and irremediable effects, than when the valvular defect is the result of acute or subacute rheumatic endocarditis occurring in childhood or early adult life.

Compensation.—The bearing of the state of the cardiac muscle upon prognosis is well known; hypertrophy, speaking generally, is desirable, dilatation beyond a small extent, and especially dilatation without hypertrophy, is pernicious. But it is obvious that the best condition is where the lesion is so slight, or the nutrition of the muscle and the adjustment of the nervous apparatus so perfect, that no detectible compensation has taken place. If we find a patient with aortic regurgitation, in whom a displaced apex beat, increased cardiac dulness and heaving

impulse show considerable hypertrophy of the left ventricle, we may reasonably say that his valvular lesion is so far compensated, but it is to the symptoms, and the symptoms only, that we must look, if we would judge whether this compensation is sufficient or inadequate. Given the presence of aortic incompetence, it is surely better to find the impulse normal, and no physical signs of compensation present, if the absence of dyspnœa, of pallor, of palpitation and other cardiac symptoms show that in reality the valvular lesion is effectually compensated.

Age.—Another point in prognosis is the age of the patient. In children, excluding congenital cases, cardiac disease is almost always due to rheumatic endocarditis, including the rheumatism which follows scarlet fever and that which precedes chorea. The seat of the lesion is, in the majority of cases, the mitral valve, and its effect regurgitation, although cases of stenosis are not infrequently met with in children, and, as Dr. Goodhart has suggested, may sometimes be secondary to incompetence. In children there is little danger of sudden death, and much less than in adults of dropsy and other symptoms of general venous congestion supervening. When we first see a child suffering from mitral incompetence we might suppose him to be the subject of phthisis, for he is pale, thin, and short of breath, with a quick pulse and a slight cough. There is no anasarca, no albuminuria, and no icteric tinge. Such cases undergo severe trial at the period of puberty, but if they can be guided safely up to adult life, satisfactory adaptation of the body, and we may add the mind, of the patient to the imperfect member may take place: and some of the cases most favourable of prognosis are those of mitral disease beginning in childhood.

Sex.—The prognosis of organic disease of the heart is decidedly better for women than for men, no doubt because in the majority of cases their work is easier and their lives more tranquil. Particularly in cases of mitral stenosis, to which they are more

liable than men, it is wonderful how often they recover from a desperate condition.

Combinations of Valvular Lesions.—With respect to the effect of combinations of valvular lesions upon prognosis, that of aortic regurgitation is not, so far as I know, either improved or the opposite when it is complicated by stenosis; but mitral regurgitation is far less amenable to treatment when complicated by obstruction. Primary mitral stenosis acquires a new character and additional symptoms when regurgitation is associated with it.

When aortic (or lævo-sigmoid) primary disease is complicated with mitral regurgitation as an independent lesion, the condition is clinically the same as when gradual dilatation of the left ventricle leads to mitral regurgitation as a secondary complication. The case becomes clinically mitral rather than aortic in character. Pulmonary congestion, albuminuria, general dropsy, and icterus are likely to supervene; the pulse often loses its water-hammer character, and becomes irregular, weak, and compressible. At the same time there is often some relief to cardiac pain and distress, and hæmorrhage—whether epistaxis or hæmoptysis—is less liable to occur. The last stage of all valvular lesions is much the same, and is that of mitral with tricuspid incompetence.

Statistics.—My colleague, Dr. Shaw, when Registrar at Guy's Hospital, compiled the following statistics from records of the in-patients. Of 95 cases of aortic valvular disease which proved fatal (26 without and 69 with additional mitral disease), 1 occurred in a child under 10 years old, 14 in patients between the ages of 10 and 20, 40 between 20 and 40, 33 between 40 and 60, and 3 above 60. Of 41 fatal cases of disease of the mitral valve, none died under 10 years old, 6 between 10 and 20, 14 between 20 and 40, 20 between 40 and 60, and only 1 above 60.

Sudden Death.—With respect to sudden death, Dr. Shaw found that of 34 consecutive cases which occurred in the medical

wards (excluding those from hæmorrhage), no fewer than 31 were ascribed to cardiac syncope. In 14 of these the valves were normal, in the remainder the valves were diseased, the aortic in 13 and the mitral in 7 cases. In all 7 the mitral orifice was contracted. Of the 14 cases of sudden death without valvular disease, the cardiac muscle was in a state of fatty degeneration in 8, and of fibroid degeneration in 3.

Duration.—Whatever the nature of the lesion, the kind of life which the patient is able and willing to live is a most important element in prognosis. Hard work and exposure, dissipation, starvation, and drink bring otherwise favourable cases to an early termination. Moderation in all things, an equable temper, and exemption from hard work, from muscular strain and from excitement, are conditions which prolong otherwise unfavourable cases for many years. At any time a fresh attack of rheumatism may complete the ruin of an already damaged heart; an attack of bronchitis or of pneumonia may prove too severe a strain upon an organ which sufficed very well for the ordinary calls of life; or the supervention of disease of the kidneys may induce a further and most unfavourable complication.

In private practice we see far better results than we should anticipate from hospital experience. Sir Andrew Clark has published some remarkable instances of long duration of cardiac disease with comparative health. Professor Gairdner, of Glasgow, has done the same.

The late Dr. Peacock recorded a case of extreme aortic stenosis in which the patient lived to the age of 75, and then died as the result of an operation for strangulated hernia. The same accurate observer stated as the longest period of survival, after the existence of aortic incompetence was ascertained, six or seven years, but this is certainly too unfavourable a view. I lately saw a patient of 23 with well marked aortic regurgitation, and a corresponding condition of pulse, which

had certainly lasted for ten and possibly for fifteen years, yet his health was good, and there were no signs of failure of compensation. In another young man, well-nourished, with healthy complexion, and showing no signs of dyspnœa, after coming upstairs and presenting himself for insurance, I found marked aortic obstruction and regurgitation, with hypertrophied left ventricle and water-hammer pulse. He had suffered from rheumatic fever in childhood, and had been most carefully brought up with the knowledge that he had disease of the heart. He was never sent to school, was not allowed to run about or to play any game more laborious than spillikins. At college he abstained from exercise except of the gentlest description, and when I saw him at the age of 31 he had married, and was engaged in active life with comfort. A striking instance to the same effect was furnished by the late Lord Iddesleigh, who died from cardiac syncope as the result of valvular disease, which had probably existed for more than forty years.

Valvular Disease and Life Insurance.—Whilst, however, we are fully warranted in giving a far more favourable prognosis of organic disease of the valves than fifty years ago was thought possible, yet with respect to life insurance, I cannot hold that we are justified in admitting such cases, even when the circumstances of the patient and apparent compensation seem most favourable. We must, of course, first determine whether the murmur is functional or not; its locality and rhythm, its variability, and even its quality may help us; the state of the pulse, and the evidence afforded by the patient's complexion, nutrition, and respiration are also helps, and the history of a previous attack of rheumatism may determine the balance of probabilities.

An apex systolic murmur is the one which most often causes legitimate doubt. If it cannot be traced into the axilla, if the pulse is normal in frequency and rhythm, if the apex beat is neither exaggerated nor displaced, and if no cardiac symptoms

are present, it is possible that the disturbance is only functional; but even in such a case it is wiser, I think, to defer completing the insurance, and to examine the patient again after a few weeks' interval. If the murmur, which was the only sign of disease, has disappeared, we may then recommend him with confidence. A transient systolic murmur, however loud, is almost always functional, not only in nervous and excitable women, but in robust young men. Under the excitement of an examination the pulse often doubles in frequency, the cardiac action becomes violent, thumping and distressing to the patient, and a loud blowing murmur is audible at the apex and epigastrium. Whether this is always due to temporary tricuspid incompetence is difficult to say, but if the sitting attitude is assumed the cardiac excitement rapidly subsides, the pulse regains its normal frequency, and the murmur becomes fainter and speedily disappears. One can often hear it at the close of the inspiratory period before it ceases altogether. A similar temporary, but loud and obvious, systolic *bruit* may be heard in perfectly healthy youths after they have run themselves out of breath.

Treatment.—The tranquillity of body and of mind, the avoidance of occasions of strain to the heart, and of injury to the lungs or kidneys, which justify a favourable prognosis, are also most effectual treatment of disease of the heart. So far as drugs are concerned, it is remarkable that our most decisive successes are gained in what appear to be the worst cases. Aortic valvular disease and mitral obstruction in their early and uncomplicated stages are often little influenced by any direct medication; but when primary or secondary mitral regurgitation has taken place, when the patient is water-logged and jaundiced, with failing breath, scanty albuminous urine and fluttering pulse, then it is that digitalis is so invaluable a remedy. Taken frequently as an infusion, or in the admirable combination with squill and black oxide of mercury which

has been called "the infallible pill,"—it is wonderful to see how the kidneys secrete, the dropsy disappears, the pulse becomes steady, and the patient is rescued from imminent peril.

There was once a cabman with advanced mitral regurgitation, who five several times, at varying intervals, came under my care at Guy's Hospital, each time dropsical and breathless. Four times he went out feeling well and able to return to work; on the fifth occasion the disease, which had been so often warded off, proved fatal.

When the dropsy is large, and the urine very scanty, it is desirable to procure more rapid relief, and to give a better chance for the diuretic action of the pill, by first tapping the abdomen if there is considerable ascites, or by what is more generally applicable, acupuncture of the legs. I have tried Dr. Southey's tubes as a substitute, but having seen ill effects in one case—though I have since used them with advantage—I think the plan of numerous incisions with a lancet, deep enough to go through the skin, is, as a rule, safer and more effectual. If the legs are first well smeared with cold cream, benzoated lard, or olive oil, no inflammation is set up, whereas I have seen carbolic oil, used with the same intention, produce a painful and troublesome dermatitis.

In such cases patients find the great advantage of the sitting over the reclining posture. Again and again I have seen a patient who has passed restless days and nights in bed, breathe comfortably and fall into sound and refreshing sleep when placed in an old-fashioned high armchair with sides. The next morning much of the water which clogged his chest has gravitated into his legs, and he is ready to receive the full benefit of the acupuncture.

The introduction of strophanthus, by Professor Fraser, as a substitute for digitalis in the treatment of cardiac disease, has given us a useful addition to the *Pharmacopœia*. The action is very similar to that of the older drug, and the indications for its

use are almost the same. It certainly has not superseded digitalis, which still remains the most valuable of all medicines in disease of the heart. But sometimes we need to change a prescription which has lost some of its efficacy by long continuance, and sometimes we meet with patients whom digitalis does not suit. In either case strophanthus is a most valuable alternative. Some of the best results of its use have, in my experience, been obtained in the treatment of mitral incompetence in children. Convallaria has a similar action, but is less powerful, and acts better as a diuretic than as a direct cardiac tonic. Citrate of caffeine also is often of service. In aortic valvular disease, uncomplicated by dropsy or venous congestion, digitalis is often uncertain and sometimes dangerous. Steel when it is borne, strychnine, and in many cases arsenic, are valuable drugs, but often the most effectual relief is afforded by careful attention to the diet, with a view to ensuring easy digestion, and to avoid flatulence. Soda and peppermint, the compound spirits of horse-radish, the compound tinctures of cardamoms or lavender, a rhubarb and ipecacuanha pill, euonymin and blue-pill—drugs of this kind directed to the digestive organs, are often more effectual as cardiac sedatives than those which act directly on the heart.

Many physicians find belladonna a valuable medicine in the treatment of aortic valvular disease. I confess that I have been often disappointed in its effects.

When there is much pain and headache, with symptoms like those of aortic aneurysm, or with attacks closely resembling angina pectoris, nitroglycerine and nitrite of amyl are valuable remedies; but in many such cases the application of leeches over the sternum, or small and repeated bleeding from the arm are more efficacious than any drugs.

Ether, particularly Hoffmann's anodyne, the spiritus ætheris compositus, liquor strychninæ, and the aromatic spirits of ammonia, are particularly useful in the cardiac dyspnœa and

distress which accompany most cases of aortic disease at some period of their course.

One important point in the treatment of cardiac disease generally is the exhibition of anodynes and hypnotics. We have now a large number of them, but not more than we are glad to choose from. In advanced mitral cases with anasarca opium is usually counter-indicated, and it is seldom needed, for the distress is chiefly due to dyspnœa, and the best anodyne is that which relieves the dropsy. But in aortic cases laudanum or Dover's powder may often be given at night with great relief and without any bad effects. In such cases this form of opiate is, as a rule, preferable to subcutaneous injection of morphine. Bromide of potassium is not often effectual and its after-effects are unpleasant. Chloral hydrate is unsuitable and sometimes injurious. In cases of restlessness and discomfort rather than actual pain, a safe and useful sedative is the tincture of hyoscyamus in a dose of 40 or 60 drops in hot brandy and water.

The severe headache which sometimes accompanies the arterial anæmia of cardiac disease may tempt us to give antipyrin, but in such cases it is an uncertain and may sometimes prove a dangerous remedy. Laudanum and brandy is both more effectual and more safe. As a substitute for chloral hydrate paraldehyde has of late years been much used. It often procures comfortable rest, and I have not seen any unfavourable effect upon the heart, but its taste is disagreeable and it often fails in its object.

Chloralamide, given in scruple doses, has often acted extremely well, and I have not yet seen ill effects from it except in a single case, where it probably produced an attack of dermatitis. In some advanced cases of cardiac disease, with restlessness and distress rather than acute pain, I have found sulphonal act extremely well, rubbed up with a little tincture of lavender or curaçoa, and washed down with a wine-glass of

water ; or it may be taken in hot milk, or prepared in cachets. It sometimes fails, like other drugs, but as far as I know at present never does harm.

Another important point in the treatment of cardiac disease is the proper place of venesection. It has two important applications. No one who has watched many cases of aortic aneurysm can doubt the great value of moderate bleeding from the arm in relieving the worst pain of this terrible disease. In cases of aortic valvular disease, the symptoms are often very similar, and the same remedy seems indicated. The abstraction of four to six ounces of blood from the arm in these cases, I have sometimes found very effectual, but it is not nearly so certain a remedy as in cases of aneurysm.

The other condition in which blood-letting finds its proper place is when the right side of the heart is distended, the whole venous system engorged, the surface cyanotic, and the pulse small, weak and fluttering. In such cases the abstraction of a moderate amount of blood from the arm relieves the right side of the heart for a time, and gives the circulation a chance of recovery. I have sometimes seen this measure effectual in valvular disease, but more often have been disappointed of any lasting benefit, and believe that, on the whole, it is far less likely to be useful in primary cardiac disease, than when dilatation of the right side of the heart is the result of obstruction of the pulmonary capillaries, in cases of advanced bronchitis with emphysema or dilated tubes.

Before concluding, I ought, perhaps, to refer to Oertel's treatment of valvular disease of the heart by regulated gymnastics, but I must confess that it does not appear to me to have either physiology or experience in its favour. The object is to produce compensatory hypertrophy of the cardiac chambers, in the same way as we strengthen the muscles of a limb by regular gymnastic exercises. But in the case of the heart, its gymnastics are already provided by the necessities of the circulation. There is

no fear of its being idle, but there is great fear of its being taxed beyond its strength. So long as the general nutrition is good, the additional strain of an imperfect valvular apparatus will lead to corresponding efforts on the part of the muscle. By increasing the strain the conservative process is probably rendered more likely to cease and to be followed by dilatation. Moreover, we constantly see our patients practising Oertel's system without knowing it. It is but few who either can or will resign themselves to an inactive life with a damaged heart. They walk up hill, they lift burdens, they go quickly upstairs, and the result is in the majority of cases injurious. That patients with disease of the heart should be encouraged to take that useful place in the world which remains for many a man who is halt or maimed is most true, but their work must be mental rather than bodily, and less, not more, than that of sound men. If they will be content to work half time and half speed they may accomplish a lengthy journey, but to urge them beyond their powers is but another instance of *nimia diligentia medicinæ.*

Dr. F. J. Smith had tabulated from the records of the London Hospital during 11 years, the deaths of patients in whom cardiac disease was found. Of 950 cases, 499 died of some other complaint, not directly due to heart disorder ; this counted in favour of the prognosis in heart cases. In 550 cases bruits were heard during life. In not one case where a pulmonary bruit was diagnosed was such a lesion found. Albuminuria occurred in one-half of the cases, in many of them being due to renal disease, &c. Mitral stenosis was more common in women ; we could not ascribe this to its rheumatic origin ; he would suggest that it was because a woman's heart had less power to overcome obstructions. He had found strophanthus as a remedy for out-patients preferable to digitalis ; being safer, increasing blood tension less, giving the heart a fillip, but without giving it extra work, not upsetting the digestion, and free probably from cumulative action.

Dr. Gilbert alluded to the case of a middle aged woman, with attacks of rapid action of the heart, subject to menorrhagia, and

then to osteo-arthritis. Sir D. Duckworth had lately described the continuous and the paroxysmal rapid heart. His patient died in one of these attacks, and a cadaveric odour was perceptible for 24 hours preceding death. He emphasised the value of perfect rest in cases of valvular disease,—send the patients to bed for a week.

Dr. G. N. Pitt said there were in Guy's Museum two specimens of pulmonary endocarditis in gonorrhœa. He referred to the difficulty of prognosis in cases of mitral stenosis, where there is great nerve disturbance, and desired to learn whether, in such cases, even when the mental and physical distress were intense, a sudden death need not be feared, so long as the second pulmonary sound was not intensely accentuated, the first apical sound remained audible, and the lungs and liver showed no extreme engorgement. Yet the general condition of such patients may appear most alarming. He could not agree with the first speaker that a stenosed valve was evidence of less strain than when the valve was incompetent; on the contrary, it appeared, for example, that mitral stenosis in adults was, in a third of the cases, associated with scarred or granular kidneys, and in some was secondary to such lesions. He would also like to raise the question as to whether the presence of anasarca in young children with mitral incompetence, which did not rapidly clear up under treatment, was not strong evidence in favour of an adherent pericardium. The course of such cases appeared to be steadily down hill, and little affected by drugs. In addition to the remedies referred to by Dr. Pye-Smith, he would add iodide of potassium and nitro-glycerine in aortic cases, and citrate of caffeine as an adjuvant to digitalis in cases of anasarca.

Dr. F. C. Turner said that in many cases of mitral stenosis the left ventricle is found hypertrophied contrary to expectation; this is probably connected with granular kidney or other cause of increased strain. He thought the symptoms of ulcerative endocarditis partook rather of the nature of septic infection than of pyæmia; abscess was uncommon. He would like to know how the case alluded to was cured.

Mr. F. R. Humphreys referred to a case of ulcerative endocarditis, which, after nine weeks, recovered; there was tenderness along the course of the main arteries. Amongst other cases, he noted that of an old woman with cardiac lesions, who refused all medicines and food except calves' foot jelly and brandy, and recovered; and a young man, a great runner, who had hypertrophy and dilatation.

Dr. Pye-Smith replied: the case of ulcerative endocarditis was cured by nature.

A Meeting was held on October 22nd, 1890. Dr. STEPHEN MACKENZIE, President, in the Chair.

Mr. St. Clair Shadwell was proposed for admission as an Ordinary Fellow.

The President shewed specimens of the "*Embryo Filariæ Sanguinis Hominis*" from the blood of a patient under his care in the London Hospital. Alluding to the periodicity with which the embryos appear, commencing about 6 p.m. daily, he said that in some disordered conditions, as in this patient who is suffering from pyrexia, this periodicity is disturbed; he has the embryos swarming in the blood all day. As a rule they remain living and active on a microscope slide for two or three days or even a week, but in this case (the sixth which had been under the President's care) they die in a few hours. Prior to the onset of the pyrexia they lived well, but when the fever began the parent worms probably became moribund, and the embryos show this lessened vitality. The presence of the filariæ by no means implies disease; in China a considerable percentage of the inhabitants is infested by them, and dogs, parrots, crows, &c., have such parasites without apparent harm.

Mr. F. R. Humphreys read "*Notes on some cases of Perityphlitis.*" After stating that the chief object of the paper was to elicit discussion on the treatment, especially as to operation, he gave a summary of the notes of six cases. In two there had been a history of previous attacks; in the remaining four there was a marked liability to catarrhs. The sexes were equally represented, the ages varying from 14 to 60, four of them being between 27 and 36. Some degree of peritonitis was always present when the cases were first seen. The most marked symptoms were abdominal pain, vomiting, jaundice (slight, but with cerebral symptoms), and dulness, tenderness and tumour in the right iliac fossa. This tumour was present in four cases when the writer was first called in, between the fifth and seventh day of illness, appearing later in the other two. In two of the cases

the tumour was freely moveable, and situated near the anterior superior iliac spine. In one of these a second tumour was diagnosed in the right broad ligament ; in this case and in one other an abscess formed, and ruptured, in the one case per vaginam and rectum, in the latter per rectum only, in both instances on the eleventh day from the first onset. The treatment consisted in enemata, and where apparently indicated castor oil in small doses guarded by laudanum, with outward applications of heat or cold, and quinine or valerianate of zinc, the latter in four-grain doses every four hours in one case, where hysteria co-existed with great prostration. All the patients recovered, the longest duration in five cases treated as above being 26 days ; the sixth was, under advice, treated with opium alone, and lasted 46 days. Relapses occurred in two cases, being due to leaving bed too early. Further details of the severest case were given, and some notice of the present views of surgeons on the question of operation, especially the want of agreement between American and English opinions.

Dr. F. J. Smith had examined the records of medical cases at the London Hospital during a course of years, and found that nearly 90 per cent. of cases of perityphlitis were unverified, either by operation or death. The symptoms, although fairly characteristic, localised tenderness and tumour being the chief, could not be regarded as affording a certain diagnosis unless verified.

Mr. Poland thought we might properly adopt the American term appendicitis, since it is in the appendix the disorder really begins. He would operate early when you have a tumour indicating an abscess, before the fifth day if possible. Remove the appendix when you can find it and separate it, but often you cannot find it. The vertical incision outside Poupart's ligament, without necessarily opening the peritoneum, is much to be preferred.

Mr. G. J. B. Stevens said that in many of the cases of typhlitis, or perityphlitis, there was a history of a previous attack ; the parts were then often much matted together, and removal of the appendix would be found practically impossible. Such a case lately occurred to him ; a young man of 17 was attacked, he had a relapse on going out too early, and died ;

at the post mortem the condition alluded to was found, and no operation could have been successful.

Dr. Gilbert thought that typhlitis as seen by hospital consultants differed from what is seen by the general practitioner: a large number of slighter cases recovered. He had never seen a fatal case, though some had been severe; the last was complicated by double pleurisy.

Mr. Bowkett agreed as to the large proportion of mild cases seen in general practice. A severer class, where the appendix is perforated, he would term appendicitis; in these cases operation was often needed.

Dr. Hingston Fox asked as to the causation of these cases. Why should this part of the digestive tract be the subject of recurring inflammatory attacks, in some cases many times repeated? It used to be said, a foreign body lodges in the appendix cæci. Records of late years have not supported this view; such bodies are often not found in fatal cases, whilst such bodies are discovered at autopsies, without having given rise to any symptoms. He had communicated to the *Lancet* in 1885, his belief that the presence of lymphatic organs in this part of the canal was concerned in the causation of the disorder. At no point from the fauces to the anus was there such a collection of lymphatic tissue as here; Peyer's patches at the ileo-cæcal valve form usually a continuous ring, and the appendix is closely studded with lymphatic tissue, whilst the cæcum contains solitary glands, &c. The age of the patients—who are young and growing,—and the recurrence of the attacks, show a similarity to lymphatic inflammations elsewhere, especially to tonsillitis, so that the term "abdominal quinsy" has been applied to perityphlitis. He had also met with several cases of young persons, in whom symptoms of tenderness with occasional attacks of pain in the right iliac fossa had existed during several years, and a fixed indurated mass could in some instances be felt, parallel with the iliac crest; he would compare this condition with that of enlarged tonsils, suggesting that the lymphatic organs were in a state of hypertrophy, and prone to take on inflammatory action.

The President congratulated the writer on the interesting discussion. He held that the inflammation in all cases starts from the appendix. The physician should do without the surgeon if he can, thus, as was seen in the London Hospital, 90 per cent. of cases recovered without operation. The symptoms of the disease are definite: pain, tumour, and pyrexia; it is important to distinguish whether the peritoneum is affected. As to the pathology there was great truth in Dr. Fox's view.

The appendix is a mass of lymphatic tissue, and the age of the patients favours the lymphatic hypothesis. The old idea of a plum-stone lodging in the appendix still governs treatment in some cases ; castor oil and opium are given, sometimes with a fatal result. Keep the patient under the influence of opium, it may be for a long period ; if he move too early there is great danger of relapse ; you must expect a contest with your patient on this point. He thought we need not regard the risk of anything lodging in the cæcum, mucus will be thrown out, and a foreign body will be encapsuled. The indications for operation are (1) when there is suppuration ; Mr. Humphreys' cases were remarkable for the frequency of this event, (2) the frequent recurrence of attacks. The first case operated on by Mr. Treves was one of his own. Two alternatives were put before the patient : perfect rest or operation. The first was tried fully and for a long time, finally Mr. Treves was asked to operate, and a swollen and contorted appendix was discovered, good recovery ensuing on its removal. In some cases the appendix becomes attached to other organs, probably this was so in Mr. Humphreys' case, in which a tumour was felt in connection with the broad ligament.

Mr. Humphreys shortly replied.

Dr. F. Charlewood Turner read a paper "*On certain lesions of the pyramidal cells in the cortex of the brain in fatal cases of Chorea.*"

I desire to bring under the notice of the Society some sections from the Rolandic region of the cerebral convolutions, taken from four cases of fatal Chorea in young females, which show lesions of some of the larger pyramidal cells in the deeper layers of the grey matter; and which I regard as indicating the existence of a definite, and in higher grades demonstrable, structural lesion of the pyramidal cells of the cerebral convolutions, as the immediate cause of the clinical phenomena in typical cases of chorea in young persons, and as exhibiting the nature of that lesion in its grosser degrees.

All the sections show, in varying degrees of prominence, swollen and shapeless nerve-cells in the situation mentioned, one of which, in the first specimen, is shown in the accompanying drawing by Hollick. These nerve-cells are greatly

enlarged, so as to be conspicuous in the field of a 2/3'' objective, appearing here and there amongst other nerve-cells not notably changed. Instead of the natural elongated triangular form with slightly convergent sides, these cells have a rounded outline and distended shapeless appearance, and the protoplasm is granular and hazy, forming a swollen mass in which the nucleus is obscured, or in which no nucleus is visible.

It is submitted, (1) that the clinical phenomena of typical cases of chorea are opposed to the supposition that these phenomena are due only to a functional disorder of the nervous system; (2) that those hypotheses, according to which these phenomena are explained as the direct result of vascular lesions in the central nervous system—embolic, thrombotic, or simply congestive—are insufficient; and (3) that the phenomena find a sufficient explanation in the occurrence of lesions of the pyramidal cells of the cerebral cortex, of the kind here shown to exist in fatal cases, though probably of less degree in cases of ordinary course.

(1). That in chorea there is only a functional disorder of the cerebral nervous system, without any morbid change in its structure, is the conclusion arrived at by Dr. Sturges, as a result of a critical examination of the theories propounded as to the dependence of the phenomena upon some vascular lesions in the brain and spinal cord, with the observations upon which such views have been based, and of a series of clinical observations made by himself.

But when the symptoms and course of typical cases of chorea are compared with those of functional nervous disorders of an unequivocal kind, such as epilepsy, hysteria, neuralgia, and the various forms of convulsive neurosis, it is seen that there is a very important and fundamental difference between them. In chorea the symptoms run a definite, though irregular, course, ending, with few exceptions, in complete recovery. Coming on insidiously, a longer or a shorter time after some mental shock

to which they are attributable, they are for a time ingravescent, and after continuing for a few weeks or months, with relapses, gradually subside. In the neuroses pure and simple, on the other hand, the essential factor is a constitutionally defective central nervous system, the duly balanced action of which is liable to be more or less greatly disordered by a combination of external conditions, by which ordinary persons are not so disturbed; and the phenomena of functional disorder are either transitory, as in epilepsy or neuralgia, or very persistent, as in cases of hysterical paralysis or in the spasmodic neuroses. There is not that natural cycle of events characteristic of an ordinary case of chorea, in which the course of the disease resembles that of an inflammatory lesion.

There is also in subjects of chorea a certain liability to subsequent attacks, but such liability is not comparable with the liability of an epileptic to repeated fits, or with the proneness of hysterical phenomena to recur. After even a single epileptic seizure there is a well-founded apprehension of others at any period of life.

These clinical features of typical cases of chorea occurring in children and young persons, I regard as evidence of the dependence of those phenomena on a structural lesion of the cerebral centres of corresponding course, and as incompatible with the supposition that they indicate nothing more than disordered action of the nervous system, such as occurs in an epileptic seizure or neuralgic attack.

(2). But if chorea is due to something more than a disordered action of the central nervous system—something more than an abnormal distribution of the blood-supply disturbing function, without structural derangement of the nervous tissues—there are, I think, fatal objections to the supposition that the disease may be due to embolism or thrombosis of the vessels of the brain or cord, or to mere congestion of these organs, with exudation of coagulable serum and leucocytes.

To the embolic theory, that the phenomena of chorea are dependent upon multiple emboli blocking the capillary arterioles of brain or cord, it is to be objected:

(*a*). That there is no proof either of the existence of such emboli in chorea, or of any source from which multiple miliary emboli could be discharged, or that the phenomena of chorea could be produced by such embolisms.

In Dr. Money's experiments, movements of the limbs of animals were produced resembling those in chorea, with other phenomena of a different character; but no nervous disorder with a clinical course in any degree resembling that of a typical case of chorea.

(*b*). That this hypothesis is not in accordance with the recognised etiological factors of chorea.

The only conditions known to involve a liability to the occurrence of cerebral embolism are ulcerative lesions of the left side of the heart or aorta, or possibly of the arteries leading to the brain. Sex and temperament, and emotional excitement, have no appreciable influence on the occurrence. But these last are the most important factors in the causation of chorea, which on the other hand is not associated with ulcerative endocarditis.

Equally great, I think, are the objections to the congestive and thrombotic theory of the causation of chorea, based upon Dr. Dickinson's observations.

That a high degree of vascular congestion of the brain is found in fatal cases of chorea is certain, and it is remarkably conspicuous in one of my specimens. But that active congestion of the brain and cord, with its accidents of corpuscular and serous exudation, and perivascular extravasations, is the cause of the clinical phenomena of chorea, cannot, I think, be admitted.

The effects of mere vascular congestion, even when of great severity, as in epileptic seizures, are with rare exceptions quite transitory. Such attacks, though so common in children, do

not produce chorea, though they may be followed by temporary paralysis or paresis, or by permanent damage to the brain, presumably by yielding, and consequent thrombosis, of the distended vessels.

Moreover the seat of the chief lesions observed by Dr. Dickinson, which were in the spinal cord, and in the medulla oblongata and central ganglia, does not accord with choreic phenomena indicative of a functional failure of the cerebral convolutions—the mental hebetude and the disordered movements of the limbs from loss of intelligent control.

Vascular lesions of the brain and cord attributable to congestion are of common occurrence under various conditions. I have specimens from cases of plumbism with cerebral symptoms, shewing a remarkable degree of perivascular exudation, and corpuscular hæmorrhagic extravasations are a conspicuous feature in the medulla oblongata in hydrophobia, and in the convolutions in tubercular meningitis. I think such vascular lesions in fatal chorea are attributable to the condition of exhaustion and "typhoid state" into which the patients sink, and are a result, rather than a cause, of the characteristic phenomena.

That this is so appears, I think, from a consideration of the facts adduced by Dr. Dickinson himself.

Thus, in one of Dr. Dickinson's cases, the patient, a boy aged 11, died from recent pericarditis with old pericardial adhesions at a convalescent home, after recovery from his chorea and discharge from the hospital. The more recent cerebral lesions in this case could not have been caused by the past chorea.

In another case, a girl aged 13, died with morbus cordis and slight rheumatic symptoms not apparently threatening, and the choreic symptoms "obtained little attention."

In a third instance slight choreic symptoms were first observed in a girl, aged 10, who was in hospital for rheumatism with morbus cordis, two days before her death. The child was

greatly depressed by the death of another child from chorea, and anticipated a similar fate. On the day on which she died "the movements were much increased," and she had slight hæmaturia with lumbar pain. Her death was sudden.

A fourth case is that of a woman, aged 54, who had had choreiform movements for four years. She died fourteen days after admission, from exhaustion by the constant movements. She was found to have disseminated sclerosis of the spinal cord and brain.

Of the other three cases, two died in a state of great prostration,—one with temperature rising to 104·5°, and sordes on the gums, the other in a typhoid state, with diminution of the choreic movements,—the third died with "prostration" which came on "rather abruptly."

These observations are fully in accordance with, and I think confirmatory of, the opinion above expressed, namely, that these vascular lesions, resulting from disturbance of the cerebral circulation, are not peculiar to or distinctive of chorea, but are incidental to severe chorea and its fatal termination—a result of the extreme physical and mental prostration into which the patients sink.

(3). The elaborateness of the movements in chorea is, as Dr. Hughlings Jackson has observed, "a strong warrant for the inference that the changes causing them must be seated in the brain, and not in the cord," and makes it "most probable that the convolutions are the parts diseased"; and the latter inference is in accordance with the mental phenomena associated with the motor symptoms—defect of intelligence, but not of emotional sensibility.

But the effect of emotional excitement in determining the onset of chorea shows that any structural changes resulting in the higher centres cannot have been due to active congestion of those parts, but, primarily, to a collateral anæmia of them, necessarily resulting from an excessive functional congestion of the lower emotional centres, in which the subject of it "loses his head."

If this collateral anæmia should continue too long and be severe, structural changes must result in the higher nervous elements, primarily in those parts whose nutritive state is, from whatever cause, in the least efficient condition. In such case there would result, on the restoration of the full blood supply, an engorgement of the relaxed vessels of the previously anæmiated tissue; as occurs in the extremities after too great exposure to cold. In such parts a certain period of functional quiescence would be required for the restoration of the normal nutritive state, disturbance of which, by a comparatively slight and ordinary cerebral excitement, would necessarily lead to aggravation of the nutritive break-down. And, by a repetition of such disturbing influences, a nutritive disorder might be caused of a duration, and of a degree, sufficient to account for changes in the less vitally vigorous of the nerve-cells, as great as those which the specimens exhibit.

As, moreover, these changes in the nerve-cells appear to consist in nothing more than a dropsical swelling of their protoplasm, there is nothing apparently inconsistent with their recovery under favourable conditions, in accordance with the clinical course of the phenomena.

It is not inferred, however, that the structural changes in the nerve-cells in recoverable cases are of a gravity equal to those most conspicuous in these specimens obtained from a series of fatal cases.

The presence of these lesions of the nerve-cells in the Rolandic region (upper), and the absence of notable changes in the nerve-cells in sections from other parts (anterior and posterior convolutions), would seem to indicate that in the subjects of chorea this region has, for some reason, a less reserve of nutritive capacity, or vitality.

Such a defect in the reserve nutritional capacity of the Rolandic region in children may be due to the effects of the modern requirements of education, by which, as Dr. Sturges

says, "The hand of a child may be said to be habitually over-strained"; *i.e.*, maintained in a disproportionately high state of mean functional activity.

Dr. Sturges thinks the great proneness of the hands, and especially of the right hand, to be affected in children is thus accounted for. And in a similar way we may explain the especial (or exclusive) incidence of the motor disturbance, in certain cases, on parts in active use, or to which attention was powerfully directed, at the time of the occurrence of the emotional excitement by which the disease was occasioned, several instances of which are related by Dr. Sturges. In regard to these, it is to be considered that a sudden anæmiation of a region of the cortex previously in an active functional state, must be more injurious than it would be to a part in a less active or quiescent state, because active function involves a greater production of injurious results of that action, or "fatigue substances."

If, as I believe, there is a definite brain lesion in chorea, the objects to be kept in view in treating our patients are clear.

(1). We want to keep the affected parts functionally at rest without impeding the nutritive blood supply to them, on which repair must depend. By avoidance of mental stimulus and emotional excitement, we want to do for the brain with damaged cortical nerve-cells, what we do for a limb with fractured bone, by fixing it in well-fitting splints.

(2). As in chorea, there is generally a more or less defective state of the systemic nutrition, that is, of the blood, and as a healthy state of the blood is a most important condition of repair of damaged tissues, measures directed to bring about improvement in this respect are of an importance second only to those by which "physiological rest" is procurable.

While measures for ensuring rest and quiet are wholly beneficial, the use of narcotic drugs, though they may be imperatively needed, is necessarily more or less injurious, and to be avoided as far as possible.

While attending to the most conspicuous, and in severe cases the most urgent symptoms, the need of nourishing diet, of attention to the bodily functions, and of the administration of appropriate tonics, must be equally kept in view.

The President said that chorea was a most debateable section of pathology. He wished that the changes found by Dr. Turner might prove to be the real anatomical substratum of the disease. As to the embolic theory, Dr. Jackson himself always said it was only an hypothesis; he showed at any rate that chorea was an affection of the brain, and that it must be of the highest centres. Dr. Turner's arguments against the congestive theory (of Dr. Dickinson) militate against his own hypothesis of congestion of the lower (emotional) centres. By a functional lesion we understand one not accompanied by demonstrable anatomical change, for example, in habit spasm, a twitch of the face, which may last a lifetime, yet cannot be attended by structural change which can be demonstrated. Dr. Turner would seem to make a distinct class of structural changes, lying between functional and gross anatomical change. Dr. Money did not operate on children; that he could not produce human chorea in dogs proves little. Recurrence in chorea proves little; rheumatism recurs in the same way, but this is no proof of structural changes existing. He believed himself with Cheadle that chorea is an expression of rheumatism, although this leaves the morbid anatomy unexplained. He valued Dr. Turner's observations highly, but the changes found might be the consequences rather than the cause.

Dr. Turner, in reply, pointed out that his paper referred only to typical chorea running a definite course. According to his hypothesis it was not the active functional congestion of the lower centres which did them harm, but rather the collateral anæmia which ensued, and which destroyed the activity of the higher centres.

A Meeting was held on November 12th, 1890. Dr. STEPHEN MACKENZIE, President, in the Chair.

Dr. Arthur Davies shewed a case of "*Incipient Graves' Disease*" (?) in a man, aged 35 years, a cigar maker. He stated that he had good health until six months ago, when a pail of

water was thrown over him on shipboard. Since then he had had tremors, continuous, severe, and coarse in character, and especially marked in the hands and arms. His pulse was generally rapid, 102 to 140. His eyes were prominent and staring, when first seen ; the upper lids drooped, and there was neither retraction nor failure of lid to follow globe. There was no fulness in the thyroid region. His speech was slow and jerky, his memory defective, and general mental condition impaired. His mother now states that his symptoms, in particular the tremor, are of much longer standing, and she attributes them to exposure to a blizzard in America, 5 years ago. The proptosis is now less, and marked inequality of the pupils is now observed. There is a history of insanity on his father's side.

Dr. Hingston Fox shewed a case of slight "*Graves' Disease*" in a woman, aged 45 years, who came complaining of palpitation, to which she had been liable for ten years. It comes on now usually several times a day, after a meal, or any exertion or fright, or on waking at night, lasting a few minutes. She is easily startled, but has had no special fright. The pulse has varied between 96 and 129. There is slight tremor ; much perspiration ; no special heart signs. The eyes are prominent, the lower lid retracted, but the upper lid is normal in position and movement. The right lobe of the thyroid gland is enlarged, and has been so for 20 years, not increasing. The legs are weak; no cramps; slight albuminuria, with much deposit of squamous cells. Her father had palpitation when young; the mother was nervous, and died of consumption. Thus the four cardinal symptoms of Graves' disease (palpitation, tremors, goître, proptosis) are all present, although in slight degree.

Mr. G. J. B. Stevens seldom met with the disease in general practice. Could there be *unilateral* enlargement of the thyroid from a constitutional cause?

Dr. F. J. Smith asked if diarrhœa, as in a "gastric crisis," had been observed in either case.

The President questioned the diagnosis in the first case. The inequality of pupils, extreme tremor, articulatory defect, and mental failure suggested rather general paralysis of the insane. The case required consideration; the rapidity of pulse was in favour of Graves' disease; the electrical reactions might decide the question. As to the second case the evidence of Graves' disease was more clear, but the symptoms were slight and not altogether decisive.

Dr. Davies admitted the difficulty of diagnosis. The tremor in Graves' disorder was sometimes great. He referred to three other cases under care.

Dr. Hingston Fox had seen Dr. Davies' case for him in the first instance, and the appearance and history was strongly suggestive of that diagnosis, three of the four chief symptoms being present. The case indeed illustrated Dr. Hector Mackenzie's recent comparison between Graves' disease and the results of terror: the staring eyes, tremulous hands, &c. In Dr. Fox's case, instead of one severe fright, the more common gradual development in a nervous subject was observed. No diarrhœa had occurred. Possibly in the first case the occurrence of fright in already existing incipient general paralysis had caused the present condition.

Mr. F. R. Humphreys exhibited a woman, aged 35 years, the subject of "*Raynaud's Disease.*" She had suffered blueness and swelling of the hands and feet from the age of 15. Nine years ago, when nursing a six months' infant, she had an abscess below the left olecranon process, and about this time began to feel pain in the fingers of the left hand; and the middle, and subsequently the fore-finger, became soon after black and ulcerated. In June 1887 she had an abscess in the right breast, a week after weaning. Some fingers of the right hand, which had been red, swollen and painful, now became black and ulcerated at the end; this was the case with the fore and middle fingers, and, later, the fourth finger. Her present condition is as follows: the terminal phalanges are wanting on the fore and middle fingers of the left hand, and on the fore, middle and ring fingers of the right. The finger ends are swollen, and the nails of these fingers are hooked or lost. The skin of all the fingers is glossy, red or blue, according as they are warm or cold; when blue,

evanescent dead white patches are to be seen. But the blueness comes and goes without reference to weather or season. The hands are, however, easily affected by cold, and she gets chilblains. The bone takes about three months to come away. The toes are stated to present a similar swollen, red or blue appearance. She is thin, anæmic, but intelligent. There is a history of chronic cough, but nothing to be made out showing tubercle; the heart is healthy. The knee-jerk on both sides is exaggerated, and ankle-clonus is present on the right side. She has had six children, three have died, those living present apparent signs of congenital syphilis.[1]

Dr. Walter Fowler queried whether the phalanges on the left hand were not all present? And he was inclined to consider the case rather one of inveterate onychia, perhaps connected with syphilis, or with struma.

Dr. Hingston Fox asked whether the paroxysmal character of typical Raynaud's disease was sufficiently shown to justify the diagnosis.

Dr. Arthur Davies said that Raynaud laid much stress on this feature in his original memoir.

Dr. Gilbert and **Mr. G. J. B. Stevens** remarked on the rarity of malignant onychia.

The President regarded the case as a typical one of Raynaud's disease. Onychia maligna was very rare, and was never known in a generalised form. Scleroderma sometimes complicates the diagnosis in Raynaud's disease, strangulating the part and causing quiet necrosis; but not in this case. There were all degrees of the disease: he had seen many cases; some were definitely paroxysmal; others were more chronic.

Mr. F. R. Humphreys thought at first it was onychia, but as the skin became black, and finger ends dropped off, he was convinced of its being Raynaud's disease. There was a certain paroxysmal element in its varying severity.

Dr. F. J. Smith shewed a case of "*Universal Chronic Onychitis*," brought under his notice by Mr. Wingrave. A healthy woman, aged 35 years, had suffered for ten years or more; the nails had been drying up for a year or so. There was no skin affection

[1] On a subsequent occasion the urine was tested during an exacerbation of the disease, but no albumen was found to be present.

whatever in association ; no specific history ; and the cause was quite obscure. The nails of both fingers and toes are discoloured, loosened, furrowed, curling up ; some have fallen and are not succeeded by new ones. Some of the hair has fallen.

The President said it was evidently an inflammatory condition ; was it parasitic or a simple chronic inflammation? Microscopic examination was needed to determine whether it was actually an onycho-mycosis. A rather similar condition was seen in connection with both psoriasis and eczema. Mr. Hutchinson had distinguished between the two, but the majority of speakers at the Dermatological Society were of opinion that the nail conditions were identical. The cause of the perverted nutrition was obscure.

Dr. Gilbert asked if there were any disorder of the nervous system, and **Dr. Hingston Fox** suggested the local application of liquor arsenicalis, diluted 1 in 4.

Dr. F. J. Smith also showed "*Curious Nodules on the Hands with Skin Infiltration*," in a girl, aged 19 years, with a strong rheumatic family history on the mother's side. The patient herself had had rheumatic pains, but never been laid up ; the heart was sound. The lumps had been noticed for a year, after what was called blood-poisoning ; they were painful at night ; there was no history of specific affection. Both hands and elbows were affected, being the site of fleshy nodular growths, which on the hands were large, particularly about the wrists, index fingers and radial edge of palms ; in some parts they were crowded, and produced a distorted condition, resembling acromegaly. A section taken from one of the growths was exhibited under the microscope ; it certainly pointed to rheumatic fibrous growth. The nature, however, was left quite uncertain ; the case had at first, when seen on a cold day, been diagnosed as one of Kaposi's subcutaneous sarcomata.

The President said the case was quite exceptional in his experience. Primary multiple sarcoma of the skin was very rare. Kaposi's form is pigmented, from extravasated or exuded blood. A patient of his own in the London Hospital showed this, the sections made exhibiting ink stains. It ultimately becomes generalised and tends to death. This case was quite

unlike that, and he was on the whole in favour of the diagnosis of rheumatic nodules. He presumed there was no syphilitic taint; he was the first to show that nodules, and especially on the hands, occur in connection with syphilis.

Mr. T. E. Bowkett exhibited a man, aged 59 years, with "*Multiple Fibro-lipomata.*" The patient, a labourer in a brick-field, had rheumatic fever twelve years ago, being ill seven months. About six weeks after returning to work he noticed several small subcutaneous nodules in each forearm. Others soon appeared, and have increased in number and size each year, giving rise to a good deal of pain during the last two years. The tumours are symmetrical in their arrangement, large in size, and cover almost completely the flexor surfaces of both forearms, the outer and back surfaces of the thighs, and the back as high as the iliac crests. There are some also on the abdomen. The urine is not albuminous. The heart is enlarged, and there is a well marked systolic bruit at the base, and a slight systolic bruit at the apex. There is no history of syphilis.

The President considered the case rare and remarkable. He had met with a few cases in which the disease was hereditary.

Mr. Poland said that some laid much stress on inheritance in these cases. He would recommend excision of the larger tumours, which could easily be done.

Dr. Hingston Fox referred to a case of Multiple Lipomata brought by him before this Society two or three years ago.

Mr. Openshaw had a gentleman under his care with a similar condition: his mother and grandmother had had similar tumours. In the development of most fatty tumours patients lost flesh, and it appeared to him that these lipomata were collections of fat more fibrous than the rest, and when the patient wasted these lumps remained.

A Meeting was held on November 26th, 1890. Dr. STEPHEN MACKENZIE, President, in the Chair.

Mr. St. Clair B. Shadwell was elected an ordinary Fellow of the Society.

A communication was read from **Mr. G. H. Jackson,** describing a case of "*Foreign Body impacted in the Membrana Tympani.*"

"A gentleman, aged 53 years, consulted me for a distressing noise in his right ear which he had noticed for about a month. He said it had come on when rising one morning, and had been constant ever since, but that it had not been accompanied with pain or giddiness. He could give no clue as to its cause unless it was from a cold. His health was perfect, but the hearing on the right side was found to be almost gone; the ticking of a watch being heard only when in contact with the head. Upon examining the meatus with a speculum and reflected light, I found the canal free from obstruction, but could discern a small dark object upon the centre of the drum, surrounded by a small zone of injected vessels. The membrane itself was not retracted, and looked otherwise normal. Concluding that this dark object was a foreign body in a fixed position, I first tried to effect its removal with the syringe. Then I introduced Mr. Abbott's rectangular aural forceps, and keeping the passage well illuminated, I brought away without difficulty and without pain a fragment of iron, about the size of a very small pin's head, irregular in shape, and of a dark colour. A perforation became now visible in the membrane, and this was demonstrated with the Politzer bag. The tinnitus was instantly relieved, but the hearing power did not improve for two days, after which it gradually became natural. How did this fragment of iron enter the meatus? On reconsidering, the patient remembered that he had ridden upon a locomotive engine shortly before the tinnitus commenced; it is probable that it was then that the piece of metal flew into his ear. Before coming to me he had been seen by two well-known surgeons, who considered him to be suffering from overwork, and treated him accordingly."

The President thought the case curious and unusual; the ear must have been turned to the wind, as in the usual position the opening of the meatus is well protected.

Mr. G. J. B. Stevens read notes of a case of "*Primary Syphilitic Sore on the Finger.*" On March 6th, 1889, he was

consulted by a respectable married man, an inn-keeper, about 50 years of age, for a sore on the finger, which had existed two weeks. It was a small oval indolent sore, without characteristic hardness, painful to the touch, with a tendency to spread, situated on the ulnar side of the terminal phalanx of the middle finger of the right hand. Syphilis was not suspected at first, the patient being an acquaintance of 15 years standing. He attributed the sore to a crush under a cask in his cellar. It is well known that a grazed finger-end, when inoculated with dirt, &c., will sometimes give rise to an indolent and painful sore. In such a case, in a medical friend, the nerve was divided above the wound by an eminent surgeon. In the present case the sore went on spreading and eating away the tissues towards the nail, the whole finger becoming somewhat swelled. Ammonia and bark were given, and an ointment containing boric acid and iodoform applied. A surgeon saw the case in consultation, and chloral hydrate in lotion was used, also cocain, and sol. argenti nitr. (ʒi to ʒi). About March 26th, the ulcer had increased to the size of a fourpenny piece, irregularly oval, with a deep red raised surface, minutely fungous in appearance. At a second consultation, the syphilitic nature was diagnosed, and the liq. hyd. perchlor was given internally and externally, the hand being placed on a splint. On April 3rd, the ulcer was larger, had invaded the nail, the centre of the sore greyish and disintegrating, the edge opposite to the nail pinkish red, readily bleeding; the surface finely fungating, as was well seen when placed under water. Two days later, the patient was put under ether, and the ulcer completely scooped away with a Volkmann's spoon, acid nitrate of mercury solution being applied to the base. About this time sore throat and a general lichenoid eruption were observed. After this the sore healed without further trouble, and has left very little deformity. The disease was communicated to a second person.

Mr. Charters J. Symonds had seen no less than five cases

of Hunterian chancre on the finger in medical men, acquired in obstetric practice. In this case, which he saw with Mr. Stevens, there was much swelling, and a raised surface, not like a chancre; the scraping and caustic used had saved the bone and joint. The history was often apparently free from suspicion, but he regarded all sores on the fingers which did not heal with much suspicion. In one case where the joint was much endangered, the finger was amputated (but not by him); he thought this seldom or never needful. Lately he had seen a man with a chronic sore on the second phalanx, raised, grey, something like a chancre, or like a patch of necrogenic lupus. The man had been working among cows; under lead lotion the sore healed rapidly. What was its nature?

Mr. J. Hutchinson, Junr. had observed on the knee of a dairyman a few sores like necrogenic lupus, persisting for months. From horses also you may get very obstinate sores indeed. He asked whether in Mr. Stevens' case there was any characteristic deep pigmentation around the ulcer, as shown in Mr. Hutchinson's Illustrations. The glandular enlargement in these cases is not of the usual type; there is apt to be a *painful* axillary bubo.

Mr. Poland questioned whether excision were needed in chancre on the finger.

The President alluded to the difficulty of diagnosis, and the differences existing between sores on the finger and those elsewhere. Was there any glandular enlargement, cubital, axillary or general? If such appeared beyond the immediate lymphatic territory, it might be the first sign of general infection.

Dr. Hingston Fox referred to a case of such sore on the hand of a medical student.

Mr. Stevens, in reply, said the axillary glands were enlarged early, but pain and inflammation in the glands might be a natural result of an unclean untreated sore. The mode of original infection was never revealed.

Mr. J. Hutchinson, Junr., read a paper on "*Certain Injuries of the Elbow and their Treatment.*" Selecting a few topics only, he described first, *detachment of the epi-condyle of the humerus*, a small process which stands out above the internal condyle, and protects the ulnar nerve. The accident had been attributed to muscular action, but it occurred only as a rule in boyhood, between 6 and 18 years, during the period when the epi-condyle exists as a separate epiphysis. Dislocation

outwards is apt to follow, since the internal lateral ligament is attached to the epi-condyle. Reference was made to various authors and to his own cases, showing that the detachment (with or without dislocation) is generally caused by falling forward upon the wrist. Drawings and specimens were shown illustrating the symptoms and consequences of the accident; in one case the coronoid process was fractured, in another the epi-condyle had become firmly united by fibrous tissue; the close relation of the process to the ulnar nerve was also demonstrated. The detached piece of bone can often be felt just over the nerve. In some cases serious impairment of movement has resulted, indeed this was deemed by Malgaigne and others inevitable, even ankylosis in many cases. Others have been complicated with paralysis of parts supplied by the ulnar nerve, and trophic disorders in the skin. In a case of his own where flexion was limited to ten degrees, and the muscles supplied by this nerve were wasted, he opened the elbow-joint and removed the epi-condyle; sensation returned, and flexion was increased to 50°, with a useful arm. The treatment was mainly rest on a splint, with the use of an evaporating lotion, for two or three weeks, then passive movements persistently, and the patient to be kept under observation for a long time. Turning to the treatment of *fractured olecranon*, he supposed the wiring of the fragments was not now to be advocated; even in the patella this is less practised now. Should the arm be put up in extension, or in flexion, as one surgeon advises? He thought we should extend, to keep the fragments together. It is important to put the arm up at once. Extension with a weight, in bed, has been lately tried; he used it once, but was not well pleased. The rapid *supervention of Tubercular disease on injured elbow-joint* is sometimes seen. A boy sustained a severe sprain, with much swelling and inflammation of the elbow; within three or four weeks it assumed the characteristic appearance of a strumous joint. He excised it, finding an extremely severe condition of tubercular arthritis.

Do the tubercle germs find access through the skin, or are they more probably present in the patient at the time of injury? He showed a specimen of excised articular ends, from a case of complete ankylosis of the elbow, in which the operation was done sub-periosteally, through a posterior incision. The aim is to get a strong arm rather than a very movable elbow; this case was of a farm labourer, and he could lift a chair, the elbow having a range of 60° in flexion. The common *Elbow-sprain* of young children, caused by the mother dragging the child along by one arm, consists (as elsewhere shown) in slipping of the head of the radius below the orbicular ligament. About one case daily of this injury is brought to the London Hospital. He found it could easily be imitated on the dead subject, and on dissection the condition was found as stated. A distinct click was heard both on production of the injury, and on reduction. Sometimes it was diagnosed as separation of epiphysis, but this was hardly conceivable, as the head of the radius lies free. The accident never happens after five years of age, because the head of the radius then becomes bony and no longer elastic. The treatment is simply to flex and pronate; some say supination is good. What happens when the cases are unreduced? Perhaps the child itself reduces the dislocation.

Mr. G. J. B. Stevens usually found swelling and pain present in cases of pulled elbows. He used a cardboard splint and generally found the child well next day We see many injuries of the elbow, especially since tennis has become so much in vogue. These minor items of surgery are often thought unworthy of much attention in text-books.

Mr. J. Poland asked Mr. Hutchinson's opinion on the cases of so-called ununited epiphyses of the internal condyle of the humerus recently brought before the Anatomical Society. The process was compared to the acromial process of the scapula, and outer tuberosity of the os calcis. He referred to a case of his own, of which he showed a drawing, where with dislocation of the radius and ulna inwards, there was fracture of the lower end of the humerus and of the external condyle. He agreed as to the treatment of fractured olecranon; the presence of the synovial fluid is that which hinders union.

Mr. C. J. Symonds was glad to hear Mr. Hutchinson's explanation of pulled elbow. In complicated cases of elbow injuries, excision was undoubtedly the best practice, aiming to get a firm joint, though with a limited range of movement.

Mr. Hutchinson, in reply, thought that the cases referred to by Mr. Poland showed delayed union of the epiphysis, although it was difficult to understand how it could come about.

A Meeting was held on December 10th, 1890. Dr. STEPHEN MACKENZIE, President, in the Chair.

Mr. Openshaw shewed a "*Scapula affected with Sarcoma,*" which he had excised from a Lascar, aged 28 years, who was admitted into the London Hospital, August 3rd, 1890, under the care of Mr. Waren Tay, to whom the author's acknowledgments were due. The tumour was of four months' standing, and had rapidly increased in size of late. It was painful, so that he was unable to work. On admission, a firm ill-defined swelling, about two inches in each diameter, was found just below the scapular spine, to which it was firmly fixed. The skin was not adherent, and there were no dilated veins nor enlarged glands. There was some loss of flesh; no history of syphilis. The exhibition of iodide of potassium for fourteen days had no effect, and as the patient was completely disabled, it was decided to make an exploratory incision, and, if found sarcomatous, to excise the scapula. On August 21st an anæsthetic was given, and a vertical incision made through the centre of the tumour, and a small portion removed; its section had a fibro-gelatinous appearance, and contained small spicules of bone. As it could not be shelled out, excision of the bone was decided upon, and the incision was prolonged to the inferior angle, whilst a second incision from the acromion along the spine of the scapula, completed a T. The two flaps of skin, &c. thus formed were raised and detached from the bone, and the attachments

of the deltoid and trapezius muscles divided. The acromion process was then sawn through and left in situ, thus preserving the arch of the shoulder. Each vessel divided was at once secured, 40 or more in all being treated, including the dorsalis scapulæ and supra-scapular arteries. The total loss of blood was not great. The lower angle of the bone was then freed and gradually elevated, and the various muscles detached. The vertebral border was similarly treated, the whole bone being raised and held up by lion forceps. The arm being supported, the neck of the scapula was now sawn through from before backwards, the supra and infra-spinatus muscles were divided and the bone removed. The actual cautery was used to check some free bleeding which occurred from the medulla. The wound, measuring 10 inches by 6, was washed with warm carbolic lotion and sutured, two drainage tubes being put in. These were removed next day, and the wound healed by first intention, being quite closed on the sixth day. The operation lasted 1 hour 40 minutes. Shock was severe for three days, temperature 96°, but he gradually rallied, and was apparently well in a week. When discharged, October 18th, the scar was sound, and beyond some flattening of the shoulder and lowering of the acromion by half an inch there was no deformity. The arm could be moved well in all directions save extension and adduction; the hand could be placed on the back of the head. There has been no sign of recurrence. The growth was found to involve the infra-and supra-spinous fossæ, and to have extended round the vertebral border of the bone into the subscapularis muscle. Microscopic sections showed small spindle cells with conspicuous nuclei, with a few round cells. The entire scapula was first removed by Cumming in 1808. Mr. Luke performed the operation at the London Hospital in 1828 on a girl, aged 14, for malignant disease. Up to 1888 there were 65 cases of excision of the scapula on this account. Of these, in 32 the arm was amputated; the arm in 13 had been previously removed; in 3 the head

of the humerus was simultaneously excised; and in the remaining 17 the scapula with or without a piece of the clavicle was removed. Of these 17, 6 died of the operation, 3 of recurrence, whilst 8 were cured, there being no recurrence in 6 of these some years after. 50 per cent. therefore of cases of excision of the scapula for malignant disease are cured. The tumours varied greatly in size, and no two cases were alike, but Mr. Openshaw preferred a T-shaped incision, because the vessels turn over the vertebral and axillary borders, and therefore lie in the base of each flap.

The President congratulated Mr. Openshaw on the success of the operation; it was interesting that he should have repeated one performed 62 years ago by Mr. Luke, who had only latterly passed away from us. The disease being limited to the scapula, one would hope the patient would escape recurrence.

Dr. F. J. Smith asked why the entire bone was not removed, and whether there were any myeloid cells.

Dr. Hingston Fox expressed surprise at the movements of the arm being so efficient when the greater part of the scapular fulcrum was wanting.

Mr. Openshaw, in reply, said there were no myeloid cells. The muscles were so bound together by fibrous tissue that the actual interposition of bone seemed scarcely necessary for the performance of movements.

The President shewed a specimen of "*Large Intestine with the Lesions of Enteric Fever*" associated with almost complete absence of ulcers in the small intestine. It was taken from the body of a young man, aged 27 years, a carman, who was brought to the London Hospital in an advanced stage of enteric fever, and so weak that he could give but an imperfect history. It appeared that he had had a large hæmorrhage, "half a pailful," and had passed some sloughs later. Whilst in the hospital he was extremely prostrate, but the abdomen was not distended, and there was no gurgling; some doubtful rose spots were observed. He had one attack of hæmorrhage, and a few loose stools were passed. At length coma-vigil supervened; his eyes were turned up, the

dejecta were passed under him, and he died. The autopsy revealed nothing of importance but the intestinal lesions. There were numerous ulcerations in the large intestine; hardly any in the small bowel. Usually the morbid change, which selects, of course, lymphatic tissues for its attack, does not extend beyond the cæcum, but in rare cases it spends itself, as here, entirely upon the large intestine, the solitary glands being no doubt the sites of the ulcer. It is similar also with phthisical ulceration; the author shewed a specimen at the Pathological Society some years ago in which the large bowel was affected. The distinction is not of clinical importance. It seemed that some accidental source of irritation had caused the disease to be located in the unusual site. The condition of the ulcers indicated that the patient died probably in the sixth week of the fever; the ulcers were shelling out, and there was not much trace of sloughs; the ulcers were numerous, small, with undermined edges; in the lesser bowel they were few and very small.

Dr. F. J. Smith asked whether there was any straining, such as occurs in dysentery; if so it might be of diagnostic significance. He alluded also to simple ulcers of the gut, without apparent cause, or due only to a little mass of impacted fæces. Such ulcers were never very deep; he had met with several instances.

Dr. Hingston Fox thought that such ulceration as was shewn in this specimen would have a clinical importance in regard to one measure of treatment recommended by Sir W. Jenner, and which he had used himself, viz: the introduction of a long tube into the bowels to relieve the tympanites, often so distressing a symptom in enteric. If the ulcers were quite low in the colon, as here, such a measure might be disastrous. The ulcers present seemed very characteristic, and there was nothing to suggest old bowel damage, such as might explain the incidence of the disease upon this part of the canal.

Dr. A. Davies referred to a table drawn up at St. Bartholomew's Hospital, which showed that all the cases of typhoid in which the large intestine was affected were very severe In an epidemic of the fever in a severe form at that hospital some years ago, ulceration had much affected the large

bowel. Ulceration of the large intestine in phthisis was, according to his experience at the Royal Chest Hospital, more common than was admitted in the text-books.

After a remark from **Mr. Openshaw**, the **President** replied. He said that we did meet with ulceration of the large intestine of simple character, sometimes in connection with scybala. This occurred too in cases of typhoid fever, and such cases commonly ended in perforation. Ulceration of the large bowel occurred in a number of diseases, and was sometimes called "secondary dysentery;" it is supposed to be produced by hæmorrhages, which cause sloughing. There was no note in this case of tormina or tenesmus, but the patient was too ill to give much account. Pain was noted at an early stage. He related a case of serious abdominal disorder, lasting five months; pain, frequent vomiting, up and down temperature, severe hæmorrhages. After death, besides nephritis, ulceration of the small intestine was found, characteristic of enteric, but the ulcers were all healing.

Mr. John Poland exhibited a specimen of "*Simple Comminuted Fracture of the head of the Tibia with Impaction*," taken from the body of a coalheaver, aged 38 years, who had fallen on the pavement in a drunken fit. Death took place on the third day after admission into the Miller Hospital, during delirium tremens. On admission, the day after the accident, there was considerable swelling and extravasation of blood about the upper part of the right leg and knee, with effusion into the joint. The tibia moved freely over the femur in flexion and extension, without crepitus, but some displacement of the tibial head backwards was felt in the popliteal space. Over the inner tuberosity a loose fragment of bone, with crepitus, could be felt on careful examination. Although the exact nature of the fracture could not be made out, it was known that there was a severe and complicated injury to the upper end of the tibia. The anterior and posterior tibial arteries pulsated. At the autopsy the upper end of the tibia, though freely following the movements given to the leg, was found to be slightly moveable on the shaft in the antero-posterior direction, but not laterally; the patellar and other ligaments

appeared intact. On dissection, the head of the tibia was found to be fractured almost transversely at the level of the middle of its anterior tubercle. The shaft or lower fragment was driven forwards and upwards, the anterior tubercle being fixed into the cancellous tissue of the front part of the head. An angular projection of the head of the bone was thus produced at the back, towards the popliteal space. A small triangular fragment, half inch thick, of the front of the outer tuberosity, was split vertically, but not separated, being held by the ligaments. The knee joint was thereby opened at the articular surface of this tuberosity. From the front of the inner tuberosity, a large fragment of the outer shell of bone, extending two inches from the articular margin, was detached and freely moveable, and a smaller piece was split off behind this. The crucial and all other ligaments were uninjured, as were the femur and fibula. The articular cavity was full of blood, and the patella showed the usual appearance of a stellate fracture from direct violence without separation of fragments. No other lesions were found, except old valvular disease of the aortic orifice. During maceration of the bones a good deal of the cancellous tissue from the front part of the tibial head had come away, so that the fixation of the tubercle in the head was not now so marked. Transverse fractures of the upper end of the tibia in adults were usually compound, and accompanied by considerable vertical fracture into the knee joint. But here, there was only a small fragment of the outer tuberosity, involving its articular surface, and thus opening the joint, but not separated. From the stellate fracture of the patella, and the impaction of the lower tibial fragment into the upper, it may be concluded that the violence was applied to the front of the knee when it was flexed. A very similar specimen is in the Museum of St. Bartholomew's Hospital, series iii, No. 990 (a), and was described by Mr. D'Arcy Power in the xxxixth Vol. of the Pathological Society's Transactions.

Mr. Openshaw agreed that the violence was probably

direct. There was no specimen at all like it in the London Hospital Museum.

Mr. Poland alluded also to a case of comminuted fracture of the patella he had brought before the Society, where there were many fragments widely separated; he had long trouble in putting the fragments together, like a Chinese puzzle, and then wired them; in the result a very good knee was obtained.

Dr. Hingston Fox exhibited the "*Kidneys from a case of Tuberculosis.*" The patient was a colporteur, aged about 35 years, under the care of Mr. Tregelles Fox, of Strathpeffer, by whose permission the specimens were shown. The history was imperfect; its chief features were cough for years, a "fit" four years ago, habitual constipation, influenza with probably pneumonia following, and on this supervened drowsiness lasting several months till he died, semi-conscious, after repeated attacks of dyspnœa. Loss of power in the right hand and foot, incomplete, was observed six weeks before death. The body was much emaciated and the tissues dry. In the brain, an abscess was found occupying the middle of the second frontal convolution on the left side; its roof formed by closely adherent dura mater, and its sides by densely thickened tissue. Its diameter in either direction was about $1\frac{1}{2}$ inch; the contents consisted of greenish pus with shreds of brain tissue. The third convolution appeared to be pressed upon and flattened by it. Two large diverticula, without thickened walls and therefore doubtless of recent formation, extended from the abscess; the one backwards horizontally under the second frontal and ascending frontal convolutions at least as far as the fissure of Rolando, underlying the ascending frontal down to its base, but not touching the Island of Reil; it had nearly the calibre of a walnut, and was rather longer. The other diverticulum was smaller, and directed forwards and inwards near the corpus striatum; the lateral ventricle was unopened. There could be no doubt from the conditions found that the original abscess-cyst was of long standing, and that recent extension had taken

place in two directions, so as to riddle the fore part of the left hemisphere with suppurating cavities. It was surprising that they had not opened into the lateral ventricle ; the slowness of the process caused amply protective adhesion on the side of the meninges. No tubercles were found in brain or membranes. In the lungs were observed (1) an old dry encapsuled cavity at one apex, (2) pleuritic adhesions over much of the left lung, (3) a large grey consolidated area in the right lower lobe, with ragged cavities containing pus, (4) small pale yellow tubercles scattered sparsely throughout both lungs, and (5) recent hepatisation at both lower lobes (pneumonia of the dying). The heart was small and contracted, with pale ante-mortem clot in both ventricles. Large hard lumps of fæces were found throughout the colon, the walls of the bowel being thickened and whitish ; the transverse colon had sunk down to the hypogastric region. Small tubercles, similar to those in the lungs, were observed scattered in the liver and spleen. Both kidneys contained large yellow masses, forming bosses upon their surface, from the size of a cherry to that of a small plum ; some of these masses were softened in the centre, containing pus, in one or two cases a honey-combed appearance was seen on section ; the kidney tissue and pelves appeared normal.

Dr. F. J. Smith asked whether the nodules had been examined microscopically. He had seen specimens in the London Hospital Museum with honey-combed deposits, similar to these, due to actino-mycosis. This disease is commoner than is supposed, and may escape observation, looking much like tuberculosis.

The President said that the history and development of actino-mycosis were not yet fully understood. He did not think this had caused the lesions in these specimens ; they looked like tubercular lesions, and the diffusion of the disease supported it. He thought the lung mischief was most likely the oldest ; brain lesions were so rarely primary. The anatomical condition of the lungs allows of the penetration of their tissues by the bacillus. There seemed to have been two eruptions of the disease, firstly, the large nodules in the kidneys (and brain ?), secondly, the smaller nodules in the lungs, liver and spleen.

Dr. Hingston Fox said a microscopical examination had not been made. The honey-combed appearance corresponded with the figures of tubercular lesions in the New Sydenham Society Atlas of Pathology, and in Dickinson's work.

A Meeting was held on January 14th, 1891. Dr. STEPHEN MACKENZIE, President, in the Chair.

Mr. Charters J. Symonds read a paper on "*Three Cases of Hydronephrosis and their Treatment.*"

Case 1.—Edith Tozer, aged 17, was sent up to me at Guy's by Mr. Bedford, and was admitted under my care on July 18th, 1885. In the previous April she had pain "all over" with vomiting, and passed frequently high-coloured and offensive urine. There was also pain on the right side, passing round the body, and the patient noticed a swelling in the right side. Since April there had been paroxysmal attacks of pain followed by vomiting. When admitted the right loin was full and a swelling with fair outline could be felt. The urine was acid, had a specific gravity 1015, and contained about a fifth albumen and some pus. There was a creamy sediment containing some oxalate of lime. On April 17th she was for further examination put under chloroform, when a swelling could be felt reaching below the umbilicus. It fluctuated, and the lower end could be slipped up and was easily defined. The diagnosis was hydronephrosis, but as the girl appeared to magnify her troubles she was discharged on July the 22nd. Later in the same year the girl was admitted under Dr. Taylor and the cyst was several times tapped. On December 6th, 48½ ounces were removed; on January 2nd, 40 ounces; February 5th, 36; and on March 10th, 52 ounces. Thus four aspirations in about three months yielded nine pints of fluid. Three years later, in March 1888, the patient was again admitted under my care, with the cyst as large as ever. After consultation with Dr. Taylor it was

decided that the kidney should be laid open and drained, and nephrotomy was accordingly performed on April 29th. The kidney was found converted into an enormous sac, small plates only of renal tissue remaining here and there. The ureter was dilated to the size of the small intestine. A sound was passed down the ureter and went nearly to the bladder without encountering a calculus. The great dilation of the ureter and of the kidney suggested a congenital origin. I was unable to force water through the ureter into the bladder. As it was deemed better to give drainage a trial, the margins of the sac were sutured to the skin, and a large drainage tube inserted. Large quantities of fluid continued to escape, it had a sp. gr. of 1009, and contained a large amount of albumen. The urine was at this time healthy. As the presence of a sinus, discharging daily 4 to 8 ounces of urine, containing a little pus, was a source of distress to the girl, I decided to remove the whole sac. This was accordingly done on September 19th, five months after the nephrotomy, and proved to be a very simple matter. I thought that as there was a large thin-walled sac I could remove it through a small opening, much as is done in ovariotomy. An incision was made round the opening and the skin dissected back till the sac was reached, when by pushing back the superficial structures, and then the deep fascial coverings, the vessels at the hilum were reached. The pedicle was long, and was secured by passing a double ligature of thick carbolised silk. The sac appeared to have shrunk to one-third its former size. The large ureter was sutured to the skin in the lower angle of the wound, as it was too large to tie and drop back. A large tube was inserted and the wound closed. On the 22nd day she was up, and was discharged on the 28th day well, except for the small sinus leading into the ureter. The discharge from the ureter never amounted to more than a few drops.

The cause of the obstruction in this case still remains

obscure, there is probably some narrowing of a congenital kind near the vesical end of the ureter. The early history and observation of the passage of albuminous urine, suggests a possible ulceration of some part of the canal. But as at this time, 1885, there was already a tumour of considerable size, I am inclined to think that some of the contents had passed the obstruction. After the operation no blood ever appeared in the urine. The vesical orifice was not explored through the urethra.

Case 2.—*Hydronephrosis, Nephrotomy and subsequent Nephrectomy.*—Kate Kitchingham, 23, housemaid, came under Dr. Goodhart's care in December, 1887, with a five months' history of a swelling in the right lumbar region, accompanied with pain, lasting 7–10 days; then patient would pass a considerable amount of water, and the swelling would disappear. She was unable to work when the sac was full, and always complained of pain. Recurrence having frequently occurred, we decided to incise at once.

January 14th, 1888, under chloroform, the kidney was explored by the oblique incision. Its great mobility gave rise to a little trouble. The empty sac of the hydronephrosis was found, and incised fully. A little clear fluid escaped. Finger explored cavity freely without finding a stone. The papillæ were seen, for the organ being very movable could be raised well into the wound. The ureter was next defined, and found at the lower and front part of the sac in connection with the lower end of the kidney, which was almost healthy. A steel probe was passed down easily, but it was found impossible to insert a No. 6 catheter. The orifice would just take a probe and a director. By these it was dilated, and weak carbolic syringed easily into the bladder, thereby demonstrating the permeability of the canal. Dr. Goodhart thought the orifice of the ureter was not much smaller than usual. I was unable to express an exact opinion, though it was much smaller than I anticipated.

We found thus a large sac at the upper and back part of the kidney, due to dilatation of the pelvis and kidney. At the lower end a large part of the organ remained unaltered, so that the distension was unequal. This healthy part corresponded with the hard lower end of the tumour felt during life. This tumour was irregular, having a flat, hard lower end, from which rose the hydronephrotic sac. Just before the operation the sac had emptied. Not having found an exact cause for the obstruction, we could only surmise that it was due to a kinking of the ureter in a moveable kidney. We, therefore, decided to fix the organ, and drain the cavity. A large rubber tube was inserted, and fastened by a silk suture to the posterior edge of the opening in the sac. The wound was washed out with perchloride of mercury, a little iodoform dusted in, and brought together by deep silk sutures, the drain passing through the centre of the wound. Spray used. A free escape of clear fluid at once began, making frequent change of dressing necessary. Primary union took place in the rest of the wound. The urine contained for a couple of days a little blood. The urea amounted to 2.8 per cent. on first day.

20th.—Urine, sp. gr. 1024, 19 oz.; urea, 3.8 per cent.= 317·6 grains in 24 hours. No albumen.

22nd.—Specimen taken directly from the sac contained 1.8 per cent. urea, some albumen and blood; the urine from bladder contained 3 per cent. of urea.

30th.—A few drams of pus were squeezed from the wound. This came from the kidney. At times the old swelling can be felt, and on compressing, first clear fluid and then pus escapes.

Feb. 2nd.—The drain was removed, and the little finger passed into the cavity; the papilla could be felt, and the wall seemed covered with granulations. An attempt was made to remove any retained fluid without success. The sac was syringed out with carbolic acid.

March 6th the tube was removed, and the sinus closed April 5th, 1889, rather less than three months from the operation.

In September, 1889, the symptoms returned with severity. She had had several slight attacks before this date. The most severe lasted three hours.

Nov. 15th.—She was re-admitted, under my care, with a tumour slightly smaller than before. As the symptoms had recurred, we decided that the best course was to remove the kidney. This was done Dec. 7th, 1889.

Dec. 7th, 1889.—Nephrectomy. The cicatrix was opened, and the kidney exposed by dissecting off the scar tissue. The kidney could then be drawn out through a small opening. The pelvis was opened, and the orifice of the ureter could not be found, so small had it become; it was therefore decided to remove the organ. The ureter was first isolated, tied, and divided, and dropped into the wound. Then the vessels were secured by passing a double ligature through the pedicle. Deep sutures united the wound, and a large drainage tube was inserted. The drainage tube was removed on the third day. There was a rise of temperature to 103° on the third and fourth days, and the normal level was not reached for three weeks, yet the patient appeared well, and there was only a small quantity of pus daily. She was discharged Jan. 29th, with a sinus. Feb. 13th, two sutures with knots came away, and the sinus closed, *i.e.*, $2\frac{1}{2}$ months from the date of the operation.

Case 3.—Arthur Baker, aged 9, was sent up to me by Mr. Gibson, of Aldershot, who also supplied the following notes:—

The boy was run over by a carriage on February 29th, 1888, and when first seen was suffering from concussion and scalp wound. He complained also of pain in the left flank. Next day the urine was red with blood, and the pain in the loin continued. Severe local peritonitis followed and lasted five days. The temperature at this time was 101° to 102°. The

peritonitis was improving, when, on March 5th, he had left pleurisy with effusion, the heart being displaced. Then he had pleurisy of the right side. Towards the end of March he had thrombosis of the left external iliac vein with some pyrexia. On April 9th a swelling was first noticed in the left lumbar region, and was thought at first to be a blood clot. On the 11th the boy felt something give way, had an urgent and sudden desire to micturate, and passed a pint of urine, after which the tumour subsided. The cyst rapidly refilled, and on April 16th Mr. Gibson aspirated, removing about four pints of fluid. This was repeated on April 27th, the same quantity being removed. On May 2nd, after a painful day, he had a sudden desire to micturate, and passed two pints of urine. Mr. Gibson, in commenting on the case said, he thought the ureter had been ruptured and that a stricture had resulted, or that a peritoneal adhesion had contracted, and so blocked the ureter. The boy came under my care on May the 4th, a little more than two months from the date of the accident; there was then a swelling occupying the left anterior lumbar region, reaching from the ribs above to Poupart's ligament below. It extended internally to the border of the rectus. The descending colon could be felt coursing along the inner border, and the boy said that he sometimes felt a lump there, which "kept running up and down." There was distinct fluctuation. In order the better to watch the progress, the urine was measured, and was found to vary from 18 to 28 ounces daily. On the 14th of May, he passed 36 ounces, on the 15th, 25, and on the 16th, 38. On the 17th, the tumour could not be found, only an ill-defined fulness remained. I watched the boy for some time, expecting the tumour would return, but up to the time of his leaving the hospital, on July the 6th, no recurrence had taken place. The boy had also a good deal of swelling of the left leg, which remained and seemed to be unconnected with the hydronephrosis. Mr. Goodhart took him into his ward for a time from

May 26th to July 6th. Mr. Gibson writes to me under date January 6th, 1891, three years from the date of the accident; the boy has grown considerably, but looks thin and pale. The cyst fills in about six weeks. It emptied two or three days ago, and the mother thinks he passed in an hour three pints of urine. When the cyst is getting full he suffers much pain, and becomes very cross and peevish. The veins also become distended and painful.

In this case neither spontaneous evacuation nor aspiration has succeeded in curing the disease, and I propose to re-admit the boy, and probably remove the kidney.

Remarks.—These cases illustrate very well the various points connected with the diagnosis and treatment of hydronephrosis. The disease is not as a rule difficult of recognition, the position of the swelling, the presence of the ascending or descending colon along the inner border, and above all the periodic subsidence of the swelling, associated with the passage of a large quantity of limpid urine, are signs, when occurring together, sufficient to mark the nature of the complaint. In one of the cases here recorded there was no spontaneous evacuation. Definite fluctuation can be obtained, and in every case all doubt may be removed by aspirating. The majority of cases require active treatment of some kind for the relief of the pressure symptoms, and of the recurring attacks of pain which attend the filling of the sac. If left to itself a hydronephrosis may, if the obstruction be removed, wither. The sac may suppurate, either spontaneously, or as the effect of repeated tappings. In some cases death has resulted from impaction of a calculus in the opposite kidney, in others from intestinal obstruction, caused by adhesion of the sac to the duodenum or other part of the intestine. Morris has collected six cases in which, after subsidence, the tumour never recurred. Rupture has proved fatal, but in one instance at least, the abdomen was opened and the life saved. The great majority of patients have died of some intercurrent malady. At the present time most are submitted to operation, and the question is what is best to be done. The prolonged relief that has occasionally followed spontaneous evacuation points to the possibility of procuring the same result by a surgical means. In a case recorded by Dr. Elder, the patient was free for $3\frac{1}{2}$ years after spontaneous evacuation. In another by Mr. Hunter—Brit. Med. Journ., 1889—evacuation was

procured by simply elevating the pelvis. Sir W. Roberts, too, had a success by manipulation. Such simple means, however, rarely succeed, and then more active methods have to be employed. Of these the simplest is aspiration through the loin, midway between the last rib and the iliac crest, and about 2½ inches behind the anterior superior spine of the ilium. This has been followed by recovery, after several repetitions. In Mr. Croft's case it followed after eight tappings. This was a traumatic case. In the first of my cases no improvement whatever occurred, and this is the usual result. The next question is as to whether the sac should be incised and drained, or whether it should at once be extirpated In two of my cases it will be seen that I first performed nephrotomy, and only after the failure of this plan, removed the kidney.

In Tozer's case I yielded to the expressed wish of the physician, with whom I was associated, my own opinion being, that as the dilated condition of the ureter pointed to an insurmountable obstruction, the best plan would be to remove the organ at once. In Kitchingham's case we had to deal with a moveable kidney, and one in which the ureter was patent. We differed as to whether the renal orifice of the ureter was or was not contracted, but I think, as it subsequently proved, there was narrowing, for at the second operation no orifice could be found till the kidney was removed. In this case then I hold we were justified in draining. It was possible that by fixing the unduly moveable kidney, a tendency to kinking the ureter might have been removed. At the same time, acting on my own view that the orifice of the ureter was narrower than it should be, I forcibly dilated it. In this case the tube was retained two months, and the sinus closed one month after its removal. After this the patient appeared to be quite well, and we thought that a good result had been obtained, but the symptoms soon returned. The question of drainage, or rather of incision, turns, it seems to me, on the number of cases that depend on a cause which it is possible to remove. Amongst these are an impacted calculus and a moveable kidney. Out of 32 acquired cases, Roberts found an impacted calculus in 11, and we may assume that in some of these at least the stone could have been removed. The principal objection to nephrotomy is, that a sinus is likely to persist or the tumour to re-form. Gross found that a sinus persisted in 11 out of 20 cases, or in 55 per cent. Most patients will not endure a sinus, and in some it is quite sufficient to interfere with the earning of a livelihood, therefore nephrectomy has subsequently to be performed. Now, failure to find the obstructing cause is

due to the fact that the majority of surgeons have operated by the lumbar method, through which opening it is impossible to explore the whole length of the ureter, even with the finger at the same time in the rectum or in the vagina, as the case may be. Dr. Cullingworth found in an abdominal case a calculus in the lower end of the ureter and removed it, and though the patient died, still the possibility of removing a stone and of suturing the ureter was established. Later my colleague, Mr. Arbuthnot Lane, successfully removed a calculus from the ureter after having failed to find it by the lumbar incision. Neither of these patients had a lumbar tumour. The latter had symptoms of renal calculus.

The conclusion that seems most in accord with the results obtained up to the present time, is that in cases of recurring hydronephrosis, the sac should be opened through the loin and explored, the mobility of the kidney considered, the kinking of the ureter, the presence of a calculus sought. If the ureter be pervious, then an attempt should be made by fixing the kidney, and suturing the sac to the skin, to avoid removal. If, on the other hand, the ureter is found contracted to such a degree as to render dilatation impossible, the organ should be removed. In these, as in all cases, the vesical orifice of the ureter should be examined for the presence of a stone. If nephrectomy be necessary, the existence of a sinus does not, in my experience, increase the difficulty of the operation, as stated by Thornton. Indeed, it appeared to render the operation much more simple and easy. When there is no periodic subsidence there is more ground for immediate nephrectomy. Still, in these cases a calculus may be found, and at least should be sought for in the ureter, whatever method be adopted. Again, the prospect of relief by nephrotomy is much greater in the acquired than in the congenital form, for in the latter class a constriction is much more frequent. Then the next question is, when we have decided to remove the kidney, what method should be adopted? If a lumbar incision has been made, or a sinus exist, the loin route would naturally be selected. If a primary nephrectomy be decided upon, the choice lies between the lumbar and the abdominal methods. There are two main points in favour of the abdominal route; first, that we can be certain of the condition of the opposite kidney. The lamentable instance in which a solitary kidney was removed by the loin will be remembered, and in other cases the better of the two kidneys has been removed. But these were instances of calculus, pyelitis, or tubercle. In hydronephrosis, the obstruction of the ureter, and the suspended function of the kidney, prove

the soundness and sufficiency of the opposite organ, and, so far as this disease is concerned, dispose of the objection. Not so easily, however, can the second point be met, viz., that by the abdominal method, the presence of a calculus in any part of the ureter can be ascertained. When the numerous cases of exploration of the kidney by the loin are remembered without the discovery of any cause for the renal pain, the truth of this point in favour of the abdominal method becomes established. There is no more striking instance than that of Mr. Lane's, already quoted. Certainly in hydronephrosis, especially in the acquired form, if we are ever to search for a removable cause instead of removing the kidney, the abdominal route must be selected. I do not think that at present we are in a position to formulate any statement on this point. The majority of surgeons prefer the lumbar route, and in hydronephrosis, judging from my two cases, the operation is much simplified owing to the length of the pedicle. In hydronephrosis there appears to me but one objection to the lumbar method, and that is the inability to examine the whole length of the ureter. In congenital cases this is of little moment, but in the acquired, an organ of which a good half or third remains, may be removed, when the extraction of a calculus from the lower part of the ureter might alone be necessary. Still, in favour of the lumbar method, there is the important point, that by incising the sac we can ascertain the condition of the renal orifice of the ureter. Personally I give my adhesion to the lumbar method for hydronephrosis, and having once removed the kidney by this route for tubercle, I prefer it for those affections not producing great solid enlargement. My experience of the abdominal method is limited to two cases of large sarcomata in children.

Mr. R. Clement Lucas thought the paper full of practical suggestions. The third case reported might be of a different kind to the others, a peri-nephrosis, which often occurs after injury; the ureter or the pelvis is wounded, and fluid collects outside. In other cases of injury the ureter becomes strictured, causing dilatation behind. Moveable kidneys are really of great importance, and should be actively treated This affection used to be regarded as a remote curiosity, so that the Pathological Society appointed a Committee to ascertain whether there was such a thing. They are sources of danger; an attack of sudden pain may occur, the kidney dropping over and compressing the ureter, thus arresting excretion. Such mobility is in many instances the cause of hydronephrosis. Thus a woman aged 27 years had noticed a tumour since February last; it could be

dropped readily to the pelvic brim, and in other directions; it contained fluid. He removed it a few weeks ago through an opening four inches long; 24 ounces were removed by tapping; very little kidney substance was left; the ureter was not dilated. She was out of bed on the sixth day, and recovered well. In another case, seen four or five years ago, a solid kidney could be felt on the right side, dropping to below the level of the umbilicus, and it could be pushed up out of reach. This kidney has now become hydronephrotic. Again, moveable kidney is frequently associated with stone, and the urine pent up from this cause. It is therefore a serious disorder, and should be treated, the kidney being stitched up and fixed. As to draining hydronephrotic kidneys, he would not in any case do this, although eight years ago he said, on the experience of others, that they should be so treated. He had never done it; an awkward sinus would be left, and if this be closed the hydronephrosis may probably recur. Aspiration is useful for diagnosis, and unless this cures, as in a case brought before this Society by Mr. Corner, the organ should be removed. Perinephrosis has subsided after repeated tapping. There is no anxiety in removing a hydronephrosis; after exposing the tumour, tap it, it shrinks, the organ is non-adherent, and readily comes away. He had lately seen in consultation a woman with a loin tumour, which had been coming and going for five and a half years, a flow of blood occurring and the swelling subsiding; this had occurred seventy times. The cause was obscure, probably a calculus partly blocking the ureter; perhaps it might have been a villous growth. For a month there had been distension from ribs to pubes, tense, tender; and rupture was to be feared. In another case, a little stout woman, he operated a year ago; the urine contained much pus and blood. Four inches of fat had to be cut through, rendering the operation very difficult; he found the kidney dilated, with much urine and pus. He could not feel any stone with the finger, so put in a drainage tube, and washed the organ out. She did not look a strumous subject, although there was a strumous family history. He concluded to remove the kidney, but on cutting down again he found a stone far down the ureter, removed it, and the wound eventually healed.

Dr. G. Newton Pitt alluded to the causation of hydronephrosis, as illustrated by a specimen seen lately, where a vessel running along the margin of the kidney was so situated that when the pelvis was dilated the ureter was caused to kink, and so obstruction ensued. In another case the ureter was folded over a vessel and so blocked. In such cases as these change of posture might do good.

After a remark from **Mr. Poland, The President** queried what was the nature of the contraction of the ureter in Mr. Symonds' second case. There may have been a calculus, which caused ulceration and passed away, and a stricture ensued. But it is conceivable that the narrowing was congenital, the ureter becoming inadequate as the child grew, though sufficient before.

Mr. Symonds, in reply, was glad to have extracted Mr. Lucas's opinion on the question of draining, and did not doubt that surgery would take the direction indicated.

Dr. G. Newton Pitt read some "*Notes on the Tubercular Lesions found in Chronic Alcoholics*," observed *post mortem* at Guy's Hospital. In thirty cases in which phthisis was present with alcoholism, a dense fibroid pigmented change was almost invariably present in some portion of the lung, far more frequently than in other cases of phthisis. This was associated with a dissemination of fibroid tubercles in many cases, and in some with acute grey tubercles. Caseous yellow tubercles were less common, and caseous broncho-pneumonia was quite the exception. Galloping consumption due to this broncho-pneumonia is very rare in alcoholics. The presence of fibroid, and to a certain extent reparative, changes would appear to be directly associated with the large amount of alcohol which these patients have consumed. *Primâ facie* the impairment of health, due to the chronic dyspepsia and irregular habits, the lack of sufficient food, and the gross improvidence and recklessness which attend habits of intemperance, would lead us to expect that their mortality from phthisis would be high. The Registrar General's Reports, however, show that the mortality from phthisis of publicans and others whose daily occupations expose them to the greatest temptations with regard to alcohol, is rather below than above the average. Acute tuberculosis and acute pneumonia are especially liable to occur in such patients, and they are often preceded by chronic tubercular fibroid changes, but there is a great liability for the tubercular nature of the disease to be overlooked during life. Some addition

should therefore be made to the tubercular mortality of these cases in consequence of this latency of the symptoms. It is difficult to judge from *post mortem* records what proportion of cases of alcoholism die with tubercular lesions, but it is noteworthy that in about three-fourths of the cases of alcoholic neuritis, and in about one-fifth of those of alcoholic cirrhosis of the liver, tubercular changes also are found after death. The association of phthisis and tubercular peritonitis with cirrhosis is but seldom insisted on, yet it is of importance, and acute tuberculosis may usher in the final scene in a case of cirrhosis. For example, a bank clerk was admitted with a history of habitual nipping, though he was not often drunk. He was in a semi-dazed condition, he had dyspnœa, and was emaciated. On examination his liver was found to be small, and its margin irregular. There was ascites, with œdema of his legs, and the physical signs of bronchitis. His temperature rose, he became delirious and noisy, and died. The liver was found to be cirrhosed, and there was general tuberculosis. Out of 110 cases of alcoholic cirrhosis, in 23 there were tubercular lesions. Phthisis was the most common form, but in some there was acute tuberculosis, and in others tubercular peritonitis. The general conclusions were, that tubercular lesions in the lung in alcoholic subjects generally take a fibroid form, and that tubercular lesions are not infrequently associated with alcoholic neuritis and hepatic cirrhosis.

Dr. Gilbert quoted a remark of Dr. Sutton's that the only thing he knew of that would keep off phthisis was alcohol! Probably the truth is, too much alcohol predisposes to the disease, but a lesser quantity is beneficial.

Dr. F. J. Smith related two cases bearing out Dr. Pitt's views. (1). A young man had been aspirated for cirrhosis. He acquired pneumonia, which did not clear off, and died a good while after of acute hæmoptysis. Probably it was really a case of phthisis. (2). There was also a history of alcoholism in this case, a large liver, which is perhaps commoner (in cirrhosis) than a small liver, morning sickness, &c. He died of phthisis two or three months later. As regards the cirrhotic form of

lung, alcohol appears to be capable of producing small-celled infiltration of the tissues, which ultimately passes on to fibrous tissue, in the lung, as elsewhere.

Mr. C. J. Symonds asked, does alcohol make phthisis assume a fibroid type? Out in Canada people used to take whisky for this purpose. And syphilis is credited with a like effect.

The President, from his own experience, looked on cirrhosis as predisposing to phthisis. In alcoholism, it was not alone the alcohol, but the deprivation of proper food, which caused disease, such as phthisis. Dr. Wilks once raised the question, whether a person's tastes were a good guide to his conduct as to eating and drinking; and answered, it was not so. The gouty man must avoid the things he feels inclined to. It had been said that to find phthisical subjects you should go to a temperance meeting. But Dickinson and others had shown that those who give way to alcohol are more liable to tubercle.

Dr. Turner described a case of hepatic cirrhosis, dying of phthisis, in which caseous patches in the lungs were found, without marked fibrous deposit. There was ulceration of the larynx and intestine, but nothing in the peritoneum, nor were tubercular characters detected on microscopic examination.

Dr. Pitt replied; he thought alcohol in moderation beneficial to tubercular patients.

A Meeting was held on January 28th, 1891. Dr. STEPHEN MACKENZIE, President, in the Chair.

Mr. St. Clair Shadwell was admitted as an ordinary Fellow of the Society.

Dr. Dundas Grant showed a case of "*Epithelioma of the Larynx treated by Thyrotomy*" (Mr. Butlin's method) exhibited by limelight. A man, aged 50 years, came first under Dr. Grant's care last August, with a history of hoarseness for eight months, and pain in the larynx, running up to the left ear. He was tall and wasted. An ulcer was visible on the left vocal cord, and this latter was fixed both in inspiration and phonation. A small piece of the growth was removed by the forceps, the size of a split pea, and was examined by Mr.

Wingrave, who found typical concentric nests massed in it; the diagnosis of rapidly growing stratified epithelioma was made. On August 27th tracheotomy was performed, and chloroform then administered through an expansile canula. The thyroid cartilage was then opened up, and it was found that the growth extended below the vocal cords, and it was necessary to remove much of the soft parts of the larynx to get fully rid of it. The patient was kept in an atmosphere of warm eucalyptus vapour, and biniodide of mercury solution was injected from time to time through the drainage tube which was kept in. He was fed through an œsophageal tube, a thick Jacques indiarubber tube being found the most convenient. The patient's condition was now demonstrated by the limelight; a cushion of tissue of red colour being seen to occupy the site of the diseased cord. His health is good, and he has increased in weight from 9st. 8lbs. to 10st. 6lbs.

Dr. Dundas Grant also shewed a case of "*Tuberculosis of Larynx*," with especial swelling of the arytænoid cartilages. The treatment by menthol had been used, half a drachm at a time of an 8 % solution of menthol in olive oil being injected into the larynx by means of a blunt syringe with a vulcanite point. The present condition was demonstrated by the limelight; the appearances were little altered since the treatment began, but the comfort was much greater, and patient could now swallow well.

Mr. Percy Warner asked how often the menthol was applied.

The President drew attention to the unusual freedom of the epiglottis.

Mr. Mark Hovell said that many cases improved under applications of menthol, but he was more in favour of painting on lactic acid, beginning with a solution of about 30 or 40 per cent. strength, and increasing to 50 or even 80 per cent., and rubbing it well into the diseased tissues. He had seen better results from this than from menthol.

Dr. Grant, in reply, had found the lactic acid useful, especially where ulcers existed, but it sometimes irritated. He referred to a case in which Koch's treatment had been applied; after

five or six injections the appearances of laryngeal phthisis became very marked, the parts being exceedingly red; the sequel had yet to be known.

Mr. T. Mark Hovell exhibited a boy, now aged 4½ years, from whose *Larynx*, *Multiple Papillomata* were removed more than a year ago. The case was brought forward as an illustration of what could be done by intra-laryngeal methods of operating. The patient was under treatment for 10½ months. He came with the larynx filled with papillomata, attached to the cords, and the ventricular bands. There was dyspnœa, which increased, and tracheotomy had to be performed. The growths were all removed by forceps, anæsthetics being given on every occasion, and the saliva sponged away, though it is well to use the sponge as little as possible, as its contact increases the flow of saliva. An astringent, strong solution of perchloride of iron, ʒij of the crystals to ʒi of water, is found useful after the growths have been removed. The growths, numerous little rounded bodies, were shown, preserved in a bottle. And the boy's larynx was now examined by limelight, and demonstrated to be perfectly free from growths, and of healthy aspect. His voice is also of good volume and tone. Mr. Hovell remarked that he never discontinued treatment until the whole of the growths were removed, excepting when the vocal cords were eaten away, and the voice had come to be produced by the vibration of two masses of growth; in that case he left them alone.

The President congratulated both patient and operator. The patient was relieved from an obstruction to the action of his lungs, such as might have arrested his general development. The removal seemed very complete, and there was good reason to hope the disease would not recur. Was it congenital? Papillomata sometimes are so.

Dr. Dundas Grant joined in congratulation of Mr. Hovell. He referred to a case in a little girl brought before the Society last April (see p. 65), which resented all forms of treatment; cocain made her sick; chloroform nearly suffocated her. With much moral suasion, and a large relay of small mirrors and

assistants, he brought away much of the growth by forceps. The cold Leiter's coil, and a week's rest between all operations, prevented inflammation. He followed Sir M. Mackenzie's advice to leave well alone, lest the voice, after restoration, be lost again by further manipulation. Did Mr. Hovell effect the removal by sight?

Mr. Hovell, in reply, said the affection was not congenital; there was a history of four months' duration. He tried to do without tracheotomy, because of the liability to falling of the epiglottis after that operation. He carefully examined the larynx before every operation to determine the precise position of the growth, and could then, as in this case, use the forceps without actually seeing the growth he was removing. Cases of total loss of voice after removal of papilloma must be those in which the voice depends on the growth itself, or in which the larynx had been injured during the operation.

Mr. T. E. Bowkett shewed a case of *"Intracranial Murmur."* Recorded cases seemed to be in adults, and due to aneurysm. This case was in a girl, aged 4½ years, and the bruit was accidentally discovered by the mother, when lying close to the child in bed. The child was healthy, intelligent and had normal optic discs. There were a few enlarged cervical glands, and the family showed a strumous taint. The sound was of a faintly musical blowing character, audible chiefly about the base of the right mastoid process.

The President said the case was interesting and rare. In a case under his own observation, but not yet published, a child had a murmur audible in a very similar position, after a fall on the head. A projection appeared behind the ear, which became pulsatile. The balance of evidence after very careful examination and consultation, was in favour of tumour, as against aneurysm. Hemiplegia then speedily supervened, and she died. A tumour of vascular nature was found; the bone was thin and had yielded before it. This was the only case he knew of in which a tumour had grown outwards, coming through the skull. Dr. James Anderson had shown a case at the Clinical Society. Dr. Osler, of Johns Hopkins' University, in a published paper, maintained that these murmurs were often compatible with normal conditions, and not due to disease.

Dr. Hingston Fox suggested that a similar murmur might be found if searched for in many healthy persons. Many of us

can hear a murmurish pulsating sound when the head is laid on its side on the pillow.

Mr. J. Poland showed a case of "*Rheumatoid Arthritis in a Child*," accompanied by contractions of many joints in the flexed position. Emma P., aged 14 years. There was a family history of gout and rheumatism: the mother suffered for years from rheumatic pains in the joints; the mother's father had gout, and the father's brother had rheumatic fever. Her mother had had 16 children, and 2 abortions; five had died under 2½ years, 4 of diarrhœa and convulsions, 1 of pneumonia. Brothers and sisters healthy. The patient was a full term healthy child, weaned at 12 months; had whooping cough at 16 months, measles at 3 years. At the age of 2 years her present illness commenced. Without apparent cause or injury the left knee began to swell, with "burning pain" at night; she attended at Gt. Ormond Street Children's Hospital, and was handed over to the Surgeon's care. At 5½ years she became an out-patient at Guy's Hospital for three years, suffering from rickets, and wry-neck on the right side. Then her right knee began to enlarge, and she was an inmate of the Evelina Hospital for nine months. All her joints now became affected with pain, swelling and tenderness, and splints were applied to the knees. She has remained in a more or less crippled condition, but the joints have become more displaced and fixed, and at times the respiration has been much impeded. Mr. Poland first saw her 18 months ago. She is a dark-haired delicate child, with thin skin, of dull intellect, and extremely wasted, the arms more so than the legs. The joints are generally enlarged, the bones very distinctly sharing in the enlargement, especially the radius, ulna, and tibia; with contraction in the flexed position. She is able to walk with assistance, but tottering much; this has improved the last 12 months, but the ankylosed condition of the joints renders her almost helpless. The lungs and heart appear healthy; appetite is good, and the torticollis has about

disappeared. The superficial lymphatic glands in neck, groins, axilla, elbow, &c., which were much enlarged, but painless, have decreased in size. The right arm can be elevated to an angle of 40°, the left to 70°. Extension of elbows is limited; the right to 110°, but flexion is complete; the left can be extended to 135°; much creaking attends both; pronation is perfect, supination limited. There was effusion into the sheaths of extensor tendons over dorsa of both wrists; that on the left side has subsided. Metacarpo-phalangeal and inter-phalangeal joints are very much affected, the ends of the bones appearing more enlarged than is probably the case, from the wasted condition of the fingers, and there is rough creaking on movement. The left gluteal muscles are much atrophied, the great trochanter enlarged, and the thigh adducted and flexed to 135° with the trunk; flexion for about 5° is permitted, but rotation impossible. Flexion and rotation at the right hip are fairly good. The left knee can be flexed to 120° and extended to 175°, with much dry cracking; the tibia is displaced backwards and rotated outwards. The right leg is more displaced backwards, and can be flexed to 135°, with crackling sensation. The ankles move more freely, but with similar friction. Sensation normal everywhere. She has improved but little under treatment.

The President considered that as far as any case deserved the title of rheumatoid or osteo-arthritis, this did. It was rare in children. Was it a true arthritis or a spinal (medullary) arthropathy? There was no evidence in these cases of any abnormal constituent in the blood or tissues; the disease is chronic and recurrent; sweating is profuse; and the small joints are involved as they are in rheumatoid arthritis, whereas in Charcot's disease, the best example of spinal arthropathy we know, the large joints are alone affected.

After remarks from **Dr. Turner** and **Dr. Hingston Fox**, who asked whether arsenic had been given,

Mr. Rivington objected to the use of the term "rheumatism;" say rather "multiple arthritis;" there is simply disorganisation of joints. If rheumatism meant anything he supposed it meant the presence of some constituent in the blood. There was no evidence of this, and it was a pity to use

the term unless some definite signification was attached to it; it had done much harm in medicine and surgery.

Mr. Poland, replying, agreed as to dropping the term rheumatoid arthritis; but certain cases can be differentiated (like the present) as due to nerve origin. This case differed from that shown by Dr. Barlow in the marked enlargement of the bones. Mr. Makins' case showed the same. Massage, arsenic, and cod-liver oil had been used.

The Annual General Meeting was held on February 11th, 1891. Dr. STEPHEN MACKENZIE, President, in the Chair.

Dr. Thomas Marshall was admitted as an ordinary Fellow.

Dr. T. Glover Lyon was proposed for election as an ordinary Fellow.

The Reports of the Council, Treasurer, and Library Sub-Committee were read.

It was moved by Dr. Fletcher Beach, seconded by Dr. S. H. Appleford, and carried, that the Reports be received, adopted, printed and circulated amongst the Fellows.

Dr. Gilbert proposed, and Dr. Appleford seconded, a hearty vote of thanks to the President for his valuable services during the past year, which had added so much to the success of the session. This was carried by acclamation, and acknowledged by the President.

Dr. F. J. Smith proposed, and Mr. Toulmin seconded a vote of thanks to the Vice-Presidents, Treasurer, and Librarian for their services. It was carried unanimously, and acknowledged by Mr. G. B. Hicks.

A similar vote of thanks was proposed by Dr. Fletcher Beach, and seconded by Dr. Fotherby, to the Council, Secretaries and Auditors. Being carried unanimously, it was acknowledged by Dr. F. J. Smith and Mr. John Poland.

A proof copy of the Rules of the Society, as revised by the Council, was put before the Meeting by the President, copies having been already circulated among the Fellows. Resolved that the Rules, as produced, be adopted and printed, the Council being left at liberty to make purely verbal alterations that may seem necessary in the final revision of the proof.

A ballot was taken for the election of Officers for the ensuing year, and the nomination of the Council was adopted (see p. 6)

Dr. Fletcher Beach afterwards delivered the Annual Oration (see p. 18)

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